Community Outreach in Pediatrics/Psychiatry and Education Program

C.O.P.E.

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FINAL REPORT ON THE IMPLEMENTATION OF COMMUNITY OUTREACH IN PEDIATRICS/PSYCHIATRY AND EDUCATION PROGRAM IN CALGARY OCTOBER 1998 TO JUNE 2000

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EXECUTIVE SUMMARY

This report provides information about and an assessment of the Community Outreach in Pediatrics/Psychiatry and Education Program (C.O.P.E.). This program has been operating in the Calgary Board of Education (CBE) since September 1997. The program, which is the subject of this report, brings 12 pediatricians and child psychiatrists into 44 elementary schools to provide early identification and management of children with emotional, behavioural and learning problems. The program was supported through the Health Transition Fund from September 1998 to June 2000 and had five objectives that were used to structure its services:

1. Early identification of children with emotional and behavioural problems.
2. Early medical consultation and provision of comprehensive assessment of psychosocial and health status to better match needs and interventions.
3. Improvement of access and linkage to existing health and mental health services.
4. More effective utilization of health and education resources to identify and direct children to more appropriate interventions.
5. Improvement in psychosocial outcomes of children served in the program.

The participants in C.O.P.E. were drawn from kindergarten and elementary school students in the CBE which had 49,854 students enrolled as of October 1999. The study group which received the C.O.P.E. intervention had 220 participants, the equivalent-risk control group had 34 participants and the low risk comparison group had 18 participants.

The findings presented in this report describe the perceptions of key respondents including parents, school personnel and children with respect to the child's problems and changes in the child's behavioural, emotional and learning profile over the course of the study period.

Highlights of the Quantitative Findings:

- At baseline children in the C.O.P.E. program demonstrate a much higher incidence of mental disorder as compared to a national sample of Canadian school children.
- Children receiving the C.O.P.E. intervention had improved scores on psychosocial indicators. Parent responses to the change perceived in their child at 4 and 8 months reveal improvements with performance and high levels of satisfaction with the program.
- Improved parent understanding of the indicators of behavioural, emotional and learning problems. This improved capacity to identify is hypothesized to be a significant first step toward improved outcomes for children.
- Improved physician understanding of the complexities of children presenting with problems. The integration of the physician into the school-based team better enabled the physicians to provide an earlier and more complete diagnosis of the child's problems.

Highlights of Contextual and Qualitative Findings:

- Improved capacity of educators to identify and respond earlier to a broader range of mental health problems that may present in the school aged population. Consultations with teachers later in the program tended to be more focused in the information presented and had a higher level of precision.
- Very high level of need among the elementary school children with respect to learning and mental health problems.
- Presently underdeveloped linkages between schools and treatment services – especially in the realm of mental health and lack of access points that are parent and user friendly. The C.O.P.E program began the process of developing linkages that would lead to an improved system of care that would have treatment begin soon after the early identification of the problem.
- Fee for service billing is a disincentive for sustainability of physicians in school-based settings. An alternate payment plan would be beneficial to deal with issues related to length of time spent on the consultation when more than one physician is present at the consultation.
- The C.O.P.E. model is generic and has promise for application in diverse settings. C.O.P.E has one natural replication site in a rural setting – Strathmore – supported through funds from the Student Health Initiative program.
- The C.O.P.E model appears to be effective in creating partnerships around children. The program is currently being considered for integration into the broader Student Health Initiative in Calgary.

C.O.P.E is a beginning platform for developing a system of care that is integrated and based on patient rather that provider need. The process of physicians meeting children and families "at the schoolhouse door" in collaboration with educators has significant merit in improving psychosocial outcomes of children.

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1.0 INTRODUCTION AND OVERVIEW

The Community Outreach in Pediatrics/Psychiatry and Education Program (C.O.P.E.) is an integrated clinical and research program that brings 12 pediatricians and child psychiatrists into 44 school in the Calgary Board of Education to provide early identification and management of children with developmental, emotional and behavioural problems. The purpose of this report is to discuss key issues, findings, and next steps. The Health Transition Project Fund has supported the C.O.P.E. Program since September 1998.

1.1 Original Intent of Project

The original intent of the C.O.P.E. Program (a pilot program with the Calgary Board of Education in the fall of 1997) was to provide pediatric and child psychiatry outreach services to under-served, disadvantaged children and to collaborate more closely with the schools around issues such as early identification and more timely access to services for children with mental health disorders. Figure 1 depicts the service delivery model that was originally offered by the C.O.P.E. Program.

The original idea for the project came from a collaborative meeting between the Alberta Children's Hospital and the Calgary Board of Education (CBE) that sought ways to improve the care of children with severe mental health and developmental disorders. The CBE championed the project by providing a Family Liaison worker who coordinated the initial school-based consultation program which began with one developmental pediatrician and one child psychiatrist. In the first year of the program approximately 130 children were seen in various schools in Calgary. The early success of the program, stimulated interest in the medical community, and by the time the program was funded through the Health Transition Fund, two additional community developmental pediatricians and a second child psychiatrist had joined the team.

The experiences in the pilot program provided the impetus for the current project that is now complete. These specific enhancements included:

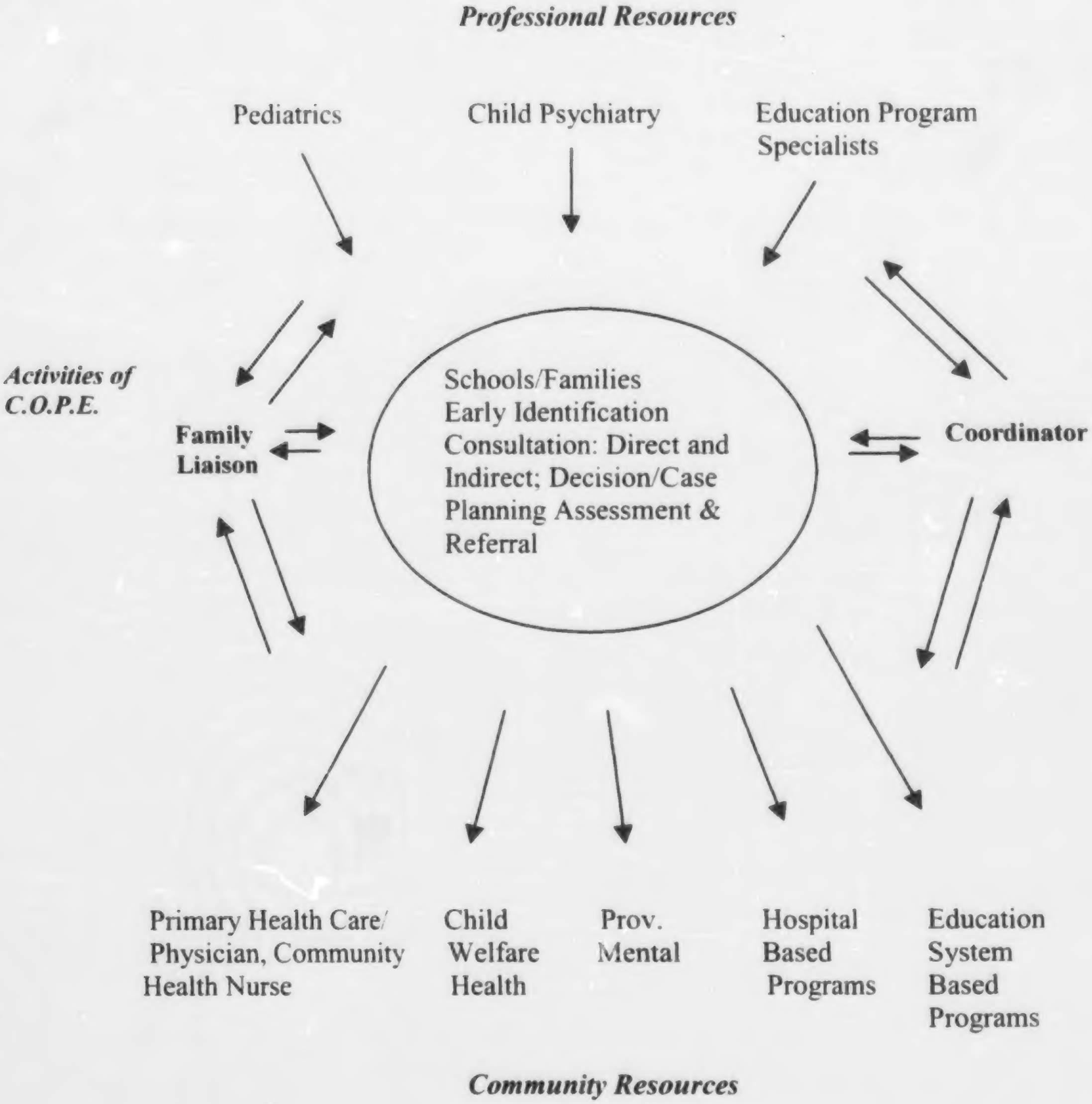
1. That the program be targeted to schools in communities known to have a significantly higher volume of need and lower probability of regular health system access.

2. The addition of a family support worker as a regular part of the team to provide follow-up and assist high-risk families gain system access.

3. Pediatricians and child psychiatrists working collaboratively on-site in the schools at the same time to allow for more effective cross-consultation on more difficult cases.

Figure 1

The Delivery Model


Professional Resources
Pediatrics
Child Psychiatry
Education Program Specialists
Activities of C.O.P.E.
Family Liaison
Schools/Families Early Identification Consultation: Direct and Indirect; Decision/Case Planning Assessment & Referral
Coordinator
Primary Health Care/ Physician, Community Health Nurse
Child Welfare Health
Prov. Mental
Hospital Based Programs
Education System Based Programs
Community Resources

1.2 Goals and Objectives of the C.O.P.E. Program

The program that was funded through the Health Transition Fund had five specific objectives that were used to structure its services. These were as follows:

1. Early identification of children with emotional and behavioural problems.
2. Early medical consultation and provision of comprehensive assessment of psychosocial and health status to better match needs and interventions.
3. Improvement of access and linkage to existing health and mental health services.
4. More effective utilization of health and education resources to identify and direct children to more appropriate interventions.
5. Improvement in psychosocial outcomes of children served in the program.

The overall goal of the project was to build on the above objectives and to identify the critical elements necessary to achieve an integrated system of care for children with mental health needs. An integrated system of care mobilizes and co-ordinates programs with professional resources to promote mental health, to prevent illness for those children not at risk, and to provide timely identification and intervention for those children who are at risk or who have already developed symptoms of a mental health disorder. A recent review of the delivery and organization of Mental Health Services in Calgary and Edmonton (Steinhauer 1999 – Review of Organization and Delivery of Children's Mental Health Services in Edmonton and Calgary) recommended implementation of a system of care approach.

1.3 Need for Project and Population Assisted by the Project

A recent review of all fee-for-service records of children 0 – 17 years of age seen from April 1 1995 to March 31, 1996 showed that mental health disorders affects a minimum of 5 to 9 percent of Alberta Children between the ages of 6 to 18 years of age (Spady, Svenson, & Gabos, 1999). Mental health disorders represented close to 10 percent of all physician billings for children aged 0 – 17 years during this time period. A needs assessment in the Calgary Regional Health Authority (Clark, 1997) showed that children living in the highest risk communities (as determined by socio-demographic indicators) were known to have a higher rate of mental health disorders. These children were shown to have a much higher utilization rate of emergency room visits for mental health diagnosis than the standard utilization rate for children (12 per 1000 emergency room visits versus 7 per 1000). It is well established that emergency room utilization for mental health disorders is often a proxy indicator of the family's inability to access other services in the health care system. In some instances this may reflect the lack of availability of primary mental health services for children. In any effect the need to offer readily accessible and timely mental health and developmental services in high risk communities was well established prior to the beginning of the current C.O.P.E. program.

1.4 Project Champions

The successful implementation of C.O.P.E. can in part be attributed to the level of support and advocacy for school-based mental health programs within the Calgary region, and the existence of two exemplary programs in the USA. Advocates of C.O.P.E. as a cost-effective approach to the early identification of children with emotional and behavioural problems championed additional support within the Calgary region, and have helped to sustain the program beyond the current funding envelope. From very early on these advocates were both the families and teachers that were served by the program. The system administrators in health and education readily saw the benefits of this model of care that was simple to implement and cost effective. The Calgary Board of Education embraced the C.O.P.E. Project and worked hard to sustain it even before receiving the Health Transition Fund monies. The creation of a Steering Committee at the early stage of implementation helped create more project champions within the sectors of Health, Education, and Mental Health. These individuals became instrumental in helping with barriers that were encountered in the implementation of the C.O.P.E. Program, and have also assisted in the sustainability of the C.O.P.E. Model. At the local level, the C.O.P.E. Program was championed by the United Way Children's Initiative. However, the program also has a number of supporters in the USA, including Dr. Mark Weist, from the Centre for School Based Mental Systems at the University of Maryland and Dr Paula Armbruster from the Yale Child Study Centre. In short, as a result of the strong collaborative model, C.O.P.E. has been successful in attracting and maintaining champions to support the continuation and further augmentation of the model. In the end, C.O.P.E. and its successes are jointly owned by a broad partnership that now includes the Calgary Regional Health Authority, The Alberta Children's Hospital, The Calgary Board of Education, and the Calgary Rocky View Child and Family Services.

1.5 History of the Project

The project had a start up phase, which occurred between August and October of 1998. The main activities during this phase of the project related to hiring of staff for the clinical and research components of the program, refinement of the clinical and research protocols within the program and preparing for implementation. The report from the Program Coordinator of C.O.P.E. details the immense amount of human and physical resources required to establish and make operational a program in three months. The C.O.P.E. Program Coordinator's Report (Section 4.2) and the accompanying C.O.P.E. Tool Kit Implementation Guide (Appendix A) outlines the elements and steps necessary to establish a program like C.O.P.E.

The early establishment of an influential Steering Committee representative of key stakeholders in mental health, and the appointment of the Project Coordinator with excellent organizational and communication skills, and who was well established within the school and health community, facilitated the smooth start-up of C.O.P.E., and the knowledge to navigate the program through the education and health communities.

The implementation phase of the C.O.P.E. program and research was not without its hurdles (discussed in detail in section 2.4). For example, a teacher's strike, budget cutbacks, and a reduction in the number of program specialists available to work in the C.O.P.E. program created problems that had to be resolved. As well, because the research component was conducted over 2 years it was often challenging to track students as they moved to new grades or into new schools.

Due to evaluation report deadlines and the end of project funding the final phase covered in this evaluation is disproportionately short (covering less than two months) with data collection for the intervention and control groups ending in April. The final months of the project are characterized by drawing upon the partnerships and collaboration establishing during C.O.P.E. to solicit sufficient funds for the continuation of the program.

1.6 Literature Review

The early identification of children with emotional, behavioural and learning problems is recognized as an essential part of the promotion of psychosocial well-being and the prevention of chronic mental and social problems in adulthood.

The need to target interventions at populations where increased rates of determinants, such as poverty, are associated with a 3 - 5 fold increase in the prevalence of childhood mental disorders is consistently identified as a priority in the literature (Offord et al., 1989; Richters and Martinez, 1993). The reason most often cited for these directed interventions is that in spite of having significant rates of psychiatric disorders, children exposed to high levels of psychosocial adversity have lower utilization rates of preventative and outpatient mental health services (Offord, 1986). In a recent study in the United States, it was found that 40 percent of inner city children were at risk for psychiatric disorders, yet only 11 percent of these at risk children had utilized mental health services (Zahner et al., 1991).

Further, children living in these high risk communities have significantly higher utilization of emergency room services and inpatient services for mental health disorders, services which are known to have lower treatment efficacy and much higher cost than outpatient services (Armbruster et al., 1997). In Calgary, a recent needs assessment revealed that children and adolescents residing in high risk communities (defined as having a volume of social needs three times greater that the average community) had a utilization rate of 12 per thousand of emergency room services for a mental health diagnosis as compared to the standard utilization rate for children between 0 - 18 years of 7 per thousand (Clarke, 1997).

The most important barrier to early identification of mental health problems, especially in childhood populations at high risk, is lack of access to a primary health care system that can identify problems and refer on to appropriate services (Armbruster et al., 1997). Many barriers to children in high risk communities accessing services have been identified including availability and acceptability. Moreover, children needing mental health services rarely seek it for themselves and are dependent on parents (who may have their own mental health problems) or teachers to recognize their needs and institute contact with appropriate services (Armbruster and Fallon, 1994). Further barriers exist when educators who are often identifying children at risk for psychiatric disorder are unable to access timely medical consultation regarding the nature of the problem and the best course of action.

School-based mental health services provide an important opportunity for the early detection of psychosocial problems and psychiatric disorders as well as providing the potential to reach a currently underserved population. Information regarding the effectiveness of school-based programs is relatively limited. Several studies in the United States have examined utilization patterns (Brindis, Kornbort, Selzer and Erikson, 1987; Dryfoos and Klerman, 1988; Seigel and Kreible, 1987), cost-effectiveness (Hill-Young, 1987; Seigel and Kreible, 1987), and satisfaction with services (Millstein, 1988), while others have reported a positive impact of school-based clinics on specific behavior problems including pregnancy (Edwards et al., 1980; Heller, 1988; Nowak, 1987; Zabin et al., 1986), substance abuse (Hill-Young, Kitzi and Welsh, 1987) and drop-out rates (Nowak, 1987). A number of US school-based clinics have been demonstrated to be effective in meeting mental health needs (Kenney, 1986; Lovick, 1988; Pacheco et al., 1991) and improving student knowledge concerning access to mental health services (Balassone, Bell and Peterfreund, 1991).

Indeed, there has recently been a proliferation in the United States both in school-based health centres (SCHCs), and in expanded school mental health (ESMH) programs (Weist, Nabors, Myers and Armbruster, 1998) in recognition of the many advantages of developing mental health programs in schools (see Adelman and Taylor, 1993; Armbruster, Gerstein and Fallon, 1997; Weist, 1997). In the United States, a nationwide ESMH initiative is being led by the Centre for School Mental Health Assistance (CSMHA), of the School of Medicine at the University of Maryland (Weist, Nabors, Myers and Armbruster, 1998). As part of this initiative, CSMHA identified areas in critical need of attention for the advancement of ESMH programs, and identified Program Evaluation to be among the highest need areas (Weist, Nabors, Myers and Armbruster, 1998; see also Kopec-Schrader, Rey, Plapp and Beumont, 1994; Kutash, Duchnowski, Johnson and Rugs, 1993).

The need to have effective early identification of mental health disorders in populations of children with higher rates of key determinants such as poverty or lack of parental education appears to be well justified. Although it has long been suggested that education and health could work together to address children's mental needs, especially in high risk communities, few programs in Canada have been implemented.

2.0 RESEARCH METHODOLOGY

2.1 Research Design Overview

An experimental, time-series research design was adopted for the C.O.P.E. research program which included one study group and two control groups (equivalent-risk and low-risk) with data collected at two or three data intervals depending on when participants were brought into the study. Participants were drawn from kindergarten and elementary school students in the Calgary Board of Education (CBE) which had 49,854 students enrolled in kindergarten to grade 6 as of October 1999 (personal communication, CBE Public Information Center, June 19, 2000). The study group (N = 220) and the equivalent-risk control group (N = 34) participants were both from socioeconomic environments associated with a high risk for emotional, behavioural, or learning problems whereas the low-risk control group (N = 18) participants were from socioeconomic environments associated with low risk for these problems.

The C.O.P.E. intervention provided to study group participants consisted of one or more consultations with one or all members of the C.O.P.E. intervention team assigned to the child's school that consisted of a pediatrician, a child psychiatrist, and the C.O.P.E. program staff. No C.O.P.E. intervention was provided to participants in either of the control-groups.

Information with respect to perceptions of the child's problems and changes in the child's emotional, behavioural, or learning profile over the course of the study period was collected from several sources. Data were compiled such that each case contained information from the child, parent(s), classroom teacher, school principal, and a CLC Specialist[1]. Information provided by the child, parent(s), and classroom teacher was specific to the child involved. Information from school principals and CLC Specialists pertained to the school or CLC as appropriate. Interviewer-administered surveys consisting of quantitative and qualitative questions (see Appendix B) were conducted with parent/child dyads at two or three time intervals depending on when the child entered the study. Self-administered surveys (see Appendix C) were completed by school principals and CLC Specialists at the outset of the study, and by each child's classroom teachers when the child entered the study.

Six cases were selected from the study group sample for case study analysis to broaden contextual understanding of the children's problems and of parental perceptions of the process and outcomes of the C.O.P.E. intervention. Cases were selected by the C.O.P.E. program staff such that a range of socioeconomic status and parental satisfaction with the C.O.P.E. intervention would be represented.

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[1] The Calgary Board of Education is organized into eight Collaborative Learning Communities (CLCs) each with a system level specialist (CLC Specialist) who works with school based personnel to meet the needs of students within the school.

Information on administrative and cross-disciplinary aspects of implementing the C.O.P.E. intervention was collected at several intervals throughout the study from all physicians (see Appendix D for guiding questions) taking part in the C.O.P.E. intervention (seven pediatricians and five child psychiatrists) and from the C.O.P.E. Coordinator and Family Liaison.

2.2 Procedure

2.2.1 Sampling

Intake into the program occurred between January and October 1999. The research plan was to include samples as outlined in Table 2.1.

Table 2.1 Target Samples by Group and Data Collection Intervals

	Study group			Equivalent-risk Control group			Low-risk Control group		
Data collection Interval	Initial	4-month	8-month	Initial	4-month	8-month	Initial	4-month	8-month
Children	200	100	100	100	50	50	60	30	30
Parents	200	100	100	100	50	50	60	30	30
Teachers	200		200	100		100	60		60
Principals	20		20	10		10	6		6
CLC Specialists	12		12	9		9	3		3

2.2.2 School Selection

Schools were selected through the current administrative structure of the CBE. The CBE is divided into eight Collaborative Learning Communities (CLC), each of which contains an average of 25 elementary schools. Area level specialists (CLC Specialists) from CBE Student Services Support are assigned to each CLC and assist school-based personnel in responding to students' emotional, behavioural, and/or learning problems. In the first year of the study, there were three CLC Specialists per CLC; in the second year there were two CLC Specialists per CLC.

The Socioeconomic Needs Index (SNI), which is a composite index of twelve social risk indicators devised by the City of Calgary (1997), was used to rank CLCs according to their relative volume of social needs. According to the SNI, communities having three times the level of social needs of average communities are defined as high-risk environments for children in terms of emotional, behavioural, or learning problems. Schools from the seven CLCs ranked highest on the SNI were randomly assigned to "study group" (four CLCs) and "equivalent-risk control group" (three CLCs) conditions. Schools from within each CLC were then randomly selected for participant recruitment into the study group (39 schools) and the equivalent-risk control group (55 schools). Four additional schools from CLCs assigned to the study group condition were selected by CLC Specialists for participant recruitment based on the perception of particularly high needs among the student population, bringing the total number of study group schools to forty-three. For the purpose of the study, low risk was defined as the CLC with the lowest SNI ranking, with schools from that CLC randomly selected for participant recruitment into the "low-risk control group" (15 schools).

Introduction of C.O.P.E. to the school system began in November 1998 in preparation for participant recruitment. The C.O.P.E. Coordinator and Family Liaison met with all CLC Specialists to explain the purpose and process of the C.O.P.E. intervention and research programs. In two of the three CLCs assigned to the equivalent-risk control group and the CLC assigned to the low-risk control group, CLC Specialists chose to independently introduce C.O.P.E. to the selected schools within their CLC. In CLCs assigned to the study-group and one CLC assigned to the equivalent-risk control group, C.O.P.E. program staff took part in introduction sessions with school principals to review the program and referral process and encourage assistance in identifying and referring potential C.O.P.E. participants. The C.O.P.E. intervention team (i.e., physicians, C.O.P.E. coordinator and C.O.P.E. Family Liaison) also took part in the initial meetings with principals of study-group schools. Initial meetings with principals of control group schools were conducted by the C.O.P.E. Coordinator and Family Liaison. Formal intake of participants into C.O.P.E. began in January 1999.

In March 1999, the C.O.P.E. Coordinator and/or the research team administrator met again with CLC Specialists working in control group CLCs because no referrals from selected schools had been forthcoming. In an attempt to reduce the work demand that assisting with recruitment into the research program created for CLC Specialists, all school principals in selected schools were then contacted directly by the C.O.P.E. research administrator during March and April 1999 to encourage participation and assist with concerns.

In CLCs assigned to the study group, participants were recruited from 43 schools (39 randomly selected schools and 4 schools selected by CLC Specialists). In CLCs assigned to the equivalent-risk control group condition, 55 randomly selected schools were approached to participate. Of these, 34 principals agreed to assist with participant recruitment, 7 declined participation, and 14 did not respond. Fifteen schools (44 percent of those agreeing to participate) were able to identify and refer potential participants. In the CLC scoring lowest on the SNI (City of Calgary, 1997), 15 randomly selected schools were approached to participate in the low-risk control group. Of these, six school principals agreed to assist with participant recruitment, three declined participation, and six did not respond. Four schools (27 percent of those agreeing to participate) were able to identify and refer potential participants.

2.2.3 Sample Recruitment

Individual children were identified for recruitment into C.O.P.E. based on the following existing CBE process for responding to emotional, behavioural, and learning needs of students. Each school within the CBE has formed a School Resources Group

(SRG) which normally consists of the school principal, invited teachers, and one or more CLC Specialist. SRG meetings are held on a regular or ad hoc basis to discuss students within the school who are having difficulties and to develop strategies for responding to students' emotional, behavioural or learning problems. Among the responses an SRG may choose is to recommend formal medical assessment of the child's mental health.

The SRG in each of the schools selected for inclusion in the study was the source of referral for C.O.P.E. intervention and/or research participation. SRGs were asked to identify potential C.O.P.E. candidates based on a descriptive behavioural profile provided by C.O.P.E. and to complete a C.O.P.E. referral form for each candidate. The descriptive behavioural profile was compiled from observations made during the C.O.P.E. pilot program conducted in collaboration with the CBE during the 1997-1998 school year. In accordance with requirements of Alberta's Freedom of Information and Protection of Privacy Act (FOIPP), school personnel also obtained parental consent to allow the CBE to refer the child to C.O.P.E. and to release contact information to the C.O.P.E. intervention and research teams. The C.O.P.E. behavioural profile, C.O.P.E. referral forms, and CBE consent form are included in Appendix E. For the study group, an SRG representative then presented the child's case during the initial C.O.P.E. consultation meeting with C.O.P.E. physicians and the C.O.P.E. Coordinator and/or Family Liaison. For the control groups, SRGs forwarded the C.O.P.E. referral and CBE parental consent forms directly to the research team.

Specialist, school principal, and teacher samples were recruited directly. A packaged containing a letter introducing the study, consent form, and self-administered questionnaire was distributed through the CBE internal mail system to all CLC Specialists within the CBE (N=24), and principals of schools selected for the study (N = 108) in December 1998. Estimated time for completion of surveys was 30 to 45 minutes. Respondents were asked to return completed surveys to the C.O.P.E. office through the internal CBE mail system. "Prompt letters" were sent to non-respondents in May 1999.

A package containing a letter introducing C.O.P.E., consent form, and self-administered questionnaire was distributed either directly or by internal mail to all classroom teachers of participating students (N = 272). It was estimated that it would take approximately one hour to complete the questionnaire. Teachers were asked to return completed questionnaires to the C.O.P.E. office through the internal CBE mail system. Between January and June 1999, the material was distributed directly to classroom teachers as children entered the study. At the end of October 1999, the same material was distributed by internal mail to classroom teachers of children who had entered the study during the 1998-1999 school year but who had changed teachers at the start of the 1999-2000 school year, as well as to classroom teachers of children entering the study during September and October of 1999. In January 2000, a follow-up reminder was sent to all current non-responding teachers. Letters of introduction, prompt letters, and C.O.P.E. consent forms for the CLC Specialist, school principal, and teacher samples are included in Appendix F.

2.2.4 Samples and Data Obtained

The number of parent/child dyads recruited and data collected for each group is reported in Table 2.2. Seventy-eight percent of the parent-child dyads in the study group sample (N = 220), 77 percent of the dyads in the equivalent-risk control group sample (N = 34), and 83 percent of the dyads in the low-risk control group sample (N = 18) were retained for the entire duration of the study period. In all groups, cases were withdrawn over the course of the study for a variety of reasons (e.g., parents withdrawing consent for further participation, parents becoming unavailable for interviews, and families moving outside of the area). In these instances, data obtained prior to withdrawal of consent were retained for analysis.

Data were obtained at two time intervals for 25 percent (n = 54) and at three intervals for 53 percent (n = 116) of parent-child dyads in the study group sample. For the equivalent-risk control group, data were obtained at two time intervals for 21 percent (n = 7) and at three intervals for 53 percent (n = 18) of the parent-child dyads. For the low-risk control group, data were obtained at two time intervals for 33 percent (n = 6) and at three intervals for 44 percent (n = 8) of the parent-child dyads. As shown in Table 2.3, the percentage of parent/child dyads retained for the entire study was similar across CLCs.

All CLC Specialists (N = 24) and principals of the schools selected for the study (N = 83) were invited to participate. The response rate was 88 percent (N = 21) for CLC Specialists and 45 percent (N = 37) for school principals. All classroom teachers of children participating in the study (N = 272) were invited to participate with an overall response rate of 64 percent (N = 175). The number of teachers responding is reported by group in Table 2.4.

Table 2.2 Number of Parent/Child Dyads and Data Obtained by Group

	Recruited		Declined	Completed Initial interview only		Completed 4-month interval interview		Completed 4- and 8-month interval interviews	
	Target	Actual		Target	Actual	Target	Actual	Target	Actual
Study group	200	220	16	0	34	100	54	100	116
Equivalent-risk Control group	100	34	4	0	5	50	7	50	18
Low-risk Control group	60	18	3	0	1	30	6	30	8

Table 2.3 Number of Parent/Child Dyads Retained by CLC

Group	CLC	Number of Parent/Child Dyads Recruited	Withdrawn prior to completion of the study	Percentage retained for duration of study
Study group				
	1	58	12	79
	5	54	13	76
	6	54	14	74
	8	54	14	74
Equivalent-risk Control group				
	2	15	4	73
	3	7	2	71
	4	12	2	83
Low-risk Control group				
	7	18	3	83

Table 2.4 Number of Classroom Teachers and Data Obtained

	Target	Actual	Response Rate (percent)
Overall	272	175	64
Study group	220	147	67
Equivalent-risk Control group	34	11	32
Low-risk Control group	18	17	94

2.2.5 Informed Consent

In all cases, a C.O.P.E. research assistant reviewed the C.O.P.E. consent form with parents to ensure they understood the purpose, process, and level of involvement being requested. Confidentiality of the information obtained through research interviews, freedom to withdraw from the study at any time, and freedom for study group participants to decline involvement in the research program without jeopardizing involvement in the C.O.P.E. intervention was emphasized. Parental consent forms for participation in study group and control group conditions are included in Appendix G.

Informed consent from CLC Specialists, school principals, and classroom teachers was indicated by completion and return of the consent form included in the package inviting their participation.

2.2.6 Parent/Child Interview

To test the hypothesis that the C.O.P.E. intervention would result in a change in children's problems and parents' responses to those problems, three rounds of structured personal interviews (i.e., initial, month four, and month eight where appropriate) were conducted with each child and parent. The series of interviews was designed to capture base-line information and information on changes that occurred over the course of the study. Data collection began in December 1998 and extended through April 2000. The first interview was conducted as near to the time of initial referral as possible and in most cases prior to the physician's consultation with the child and parent. Second and third round interviews were conducted as close to 4-month intervals from the initial interview as logistically possible. Trained research assistants conducted all three interviews. First round parent interviews were conducted in person at the child's school, whereas second and third round interviews were conducted by telephone unless the parent expressed a preference for a personal interview. Children were interviewed personally at their school for all three rounds.

Following referral of a student to C.O.P.E., a research assistant contacted parents directly to arrange a convenient time for the first interview and then contacted the school to confirm the convenience of the appointment time and the availability of a private space for the interview. During the first interview, the study was explained to the parent(s) and informed consent was obtained for parent and child participation in the C.O.P.E. program and/or in the research study. The parent was informed of their choice to decline participation in the research study without jeopardizing their participation in the C.O.P.E. program. Parents were given the option of joint or separate interviews although it was emphasized that it was acceptable if only one parent familiar with the child participated. In most cases, only one parent chose to complete the research interviews. Once permission was granted, the Parent Questionnaire was then administered. The average length of the interview was 1 to 1.5 hours although there was considerable variation depending on the parent's ability to answer. The child was then called from class and the Child Questionnaire was administered without the parent present. The average length of the child interview was 30 to 45 minutes.

Approximately four months after the initial interview, a research assistant contacted the parent to arrange a time for the second interview. Because of a high rate of missed appointments, telephone interviews were offered instead of face-to-face interviews at the child's school. Once the parent had been contacted, the research assistant contacted the school to arrange a convenient time to interview the child. Approximately four months after the second interview date, the same process was followed when interviewing parents and children being for the third round. Average time for the second and third interviews was 1 hour with parents and 30 minutes with children.

The research assistant recorded responses and any contextual observations made during the interviews on the appropriate data record sheet.

2.2.7 Case-Studies

In all cases, interviews were conducted with the mother. Three interviews were conducted in person and the others were conducted over the telephone to accommodate the schedules of the parents. The interviews were one hour in length. The researcher kept detailed hand written notes of the interviews, and included observations regarding the tone of the interview with heightened attention to the comfort level of the parent in discussing her perception and understanding of the child's problem. The perception of parents regarding what transpired in C.O.P.E. and the nature of their child's problem was compared with the perception of the teacher indicated in their response to the teacher survey, and with the perception of the C.O.P.E. physician as summarized in their assessment and filed in the child's C.O.P.E. medical file.

2.2.8 C.O.P.E. Physician Interview

One in-depth interview was conducted with each physician in the Spring of the first year of the study. These one-hour interviews were tape recorded and transcribed verbatim. The transcripts were analyzed to identify common themes and issues. Two follow-up focus group sessions were conducted with the physicians in the Fall and Spring of the second year of the study. While minutes of the focus group sessions were recorded, the researcher also kept detailed notes of the issues, challenges and observations shared by the physicians. These were then added to the themes identified in previous meetings. The intent of these interviews was to capture the physicians' perception of the success, challenges and issues related to the implementation of the C.O.P.E. program, their reasons for being involved in the program, their key areas of learning, and their recommendations to enhance the program's effectiveness.

2.2.9 C.O.P.E. Program Staff Interview

Interviews were conducted with the administration team in the spring of 1999 and 2000. The researcher kept detailed notes during the interview and the various themes and issues were that emerged were summarized. The intent of the interviews was to determine their understanding of their role in C.O.P.E., their perception of the issues, problems, and success of the program, and recommendations to improve effectiveness.

2.3 Instrumentation

To the extent possible, established research instruments were used to gather information on children's emotional, behavioural and learning problems as perceived by the child, parent and teacher. Questionnaire items were selected, and in some cases adapted, from the *National Longitudinal Study of Children and Youth* (*NLSCY*, Statistics Canada, 1995a). The *NLSCY*, being conducted by Human Resources Development Canada and Statistics Canada, began in 1994 with the purpose of developing "information for policy analysis and program development on critical factors affecting the development of children in Canada" (p. 1). A sample of approximately 25,000 children is being surveyed at 2-year intervals to follow children from birth to adulthood. Survey instruments, covering a broad range of characteristics and factors affecting child growth and development, are available for completion by children, parents, teachers, and school principals. The survey instruments were developed in consultation with an Expert Advisory Group and include items from several previous surveys, research instruments, and diagnostic checklists.

Additional questionnaire items were devised specifically for this study to inquire into children's and parent's perceptions about the process and outcomes of the C.O.P.E. intervention in the case of the study group, and the process and outcomes of school-initiated interventions in the case of the control groups.

2.3.1 Child Questionnaires

The questionnaires administered to children include items relating to relationships, school experiences, self-perceptions, behaviors, and leisure activities. In addition, children's perceptions of C.O.P.E. or school/community-based interventions they had experienced over the course of the study were probed. Questionnaires are included in Appendix B.

All questions included in the Child Questionnaire used for the initial interview were drawn from the *NLSCY Questionnaire for 10-11 year olds* (Statistics Canada, 1995b). Questions focused on children's perceptions of how well they get along with others (Friends and Family, 12 items); their attitudes towards school, school performance, and safety at school (School, 17 items); their overall self-esteem and physical appearance (About Me, 8 items); their general behavior and engagement in risk-taking activities (Feelings and Behavior, 47 items); their relationship with parents (My Parents and Me, 17 items); risk-taking behaviors (Smoking, Drinking and Drugs, 13 items); and the extent of their participation in activities outside of school and use of "free time" (Activities, 10 items). All items were presented in a forced-choice format. Because the present sample was generally younger than the sample for which the items were originally developed, some items were reworded into simpler language for use with children who did not appear to comprehend the original wording and some response scales were modified to allow increasingly direct questioning for use with children who appeared unable to distinguish between the original response options.

Psychiatric and mental health advisors to the *NLSCY* have clustered the items from the Feelings and Behavior section to form eight behavioural indices: conduct disorder (11 items), hyperactivity (7 items), emotional disorder (7 items), anxiety (2 distinct items plus 4 items from the emotional disorder index), indirect aggression (5 items), physical aggression (4 items), inattention (4 items), and prosocial behavior (10 items). The present study adopted these indices.

The Child Questionnaire used for the 4- and 8-month interval interviews replicated *NLSCY* items from the initial interview with some exceptions. Removed items were as follows: seven "School" items, four "About Me" items, two "Feelings and Behavior" items, and all "Smoking, Drinking and Drugs" items. In addition, open-ended questions developed specifically for this study were added to capture children's perceptions of their experience with the C.O.P.E. intervention in the case of study group participants and with any school-based or community-based interventions in the case of control group participants. Study group children were asked about their meeting(s) with C.O.P.E. physicians and with any others they had met to discuss the things they had talked about with the physician. Specifically, children were asked how many times they had met with a physician (or others), why they had met, what had happened at the meeting(s), what they had learned, and whether things were better or worse for them since the meeting(s). Control group participants were asked the same questions concerning anyone they had met with at their school or from outside the school. In cases where children had spoken with someone at their school, they were also asked whether or not their parent(s) was present during the meeting.

2.3.2 Parent Questionnaires

Questionnaires administered to parents/guardians asked for their perceptions of the child's social, emotional and/or learning difficulties, as well as school performance, attitudes towards school, self-image, and self-esteem (see Appendix B). Also included were questions about parents' experiences with the health care community with respect to the child's problems, and about their knowledge, awareness and access to available services. Subsequent rounds of surveys probed for changes in child's attitudes and behavior in addition to changes in parental knowledge and awareness of available resources. Questions were also included to gauge knowledge of and satisfaction with the C.O.P.E. intervention and/or school- and community-based interventions with respect to their child's emotional, behavioural or learning problems.

Questions for the Parent Questionnaire used for the initial interview were drawn from the *NLSCY Children's Questionnaire, Cycle 1* (Statistics Canada, 1995b). Specifically, questions were asked about contact with health professionals, use of medication, and experience of traumatic events ("Use of Health Professionals", 4 items); parents' perceptions of their child's educational experiences ("School Experience", 14 items); non-school activities and interests ("Activities Outside of School", 10 items); behavior ("Behavior", 48 items); relationships with adults and other children ("Relationships", 7 items). Also included were questions concerning parent/child interactions, various types of parenting practices, and basic parental care ("Parenting", 65 items). All *NLSCY* items were presented in a forced-choice format. Psychiatric and mental health advisors to the *NLSCY* have clustered the items from the "Behavior" section to form eight behavioural indices replicating the clustering of the "Feelings and Behavior" section on the questionnaire administered to children.

Open-ended questions developed specifically for this study sought parents' perceptions about their child's problems and strengths, the response of their child's school to those problems, communication between themselves and their child's school regarding their child's problems, and the family's awareness and use of non-school services for children with emotional, behavioural, and learning problems. All questions pertained to the 12-month period prior to involvement in the C.O.P.E. study. Demographic questions included education, age, family income, nationality, language, marital status, and gender.

The Parent Questionnaire was revised for the 4- and 8-month interviews. Retained *NLSCY* items were: all "Use of Health Professionals" items, three "School Experience" items, all "Behavior" items, and all "Relationship" items. An open-ended question concerning changes in parenting practices replaced the *NLSCY* based "Parenting" section. With regard to the child's problems and strengths, parents' were asked to provide their current perceptions as well the extent and nature of any changes they had noted in the child since the first interview. In the final interview, parents were asked about their current perceptions, changes noticed between the second and third interview, as well as their perceptions over the entire period of the study. In addition, open-ended questions developed specifically for this study were added to capture parent's perceptions of their experience with the C.O.P.E. intervention in the case of study group participants and with any school-based or community-based interventions in the case of control group participants. Parents of study group children were asked about their meeting(s) with C.O.P.E. physicians and with any others they had met to discuss the things they had talked about with the physician. Specifically, they were asked about the physician's understanding of their child's problem; about new information they and their child's teacher had gained; about communication of the consultation outcomes; and about what recommendations arose from the consultation, including whether they had followed up on recommendations made. Similar questions were asked concerning consultations with the C.O.P.E. Family Liaison. Parents were asked to judge the nature and extent of the impact of the consultation(s), their preference for having physicians involved in the school setting, and whether consultations had increased their awareness and use of services within the community. Parents of control group participants were asked the same questions concerning anyone they had consulted with at their child's school or from outside the school.

2.3.3 Classroom Teacher Questionnaire

The Teacher Questionnaire is included in Appendix C. Questions drawn from the *NLSCY* Teacher's Questionnaire (Statistics Canada, 1995b) include questions about the specific student, the classroom, the school, and the teacher's practices and demographic profile. Sections specific to the student were "Education" (15 items), "Behavior and Attendance" (7 items including 48 sub-items matching behavioural items making up the eight behavioural indices on the Child and Parent Questionnaires), and "Involvement of Parents" (4 items mirroring items in the "School Experiences" section of the Parent Questionnaire). In addition to these sections, there were 14 items concerning the students in the class, classroom resources and teaching practices, as well as 2 items concerning perceptions of school-wide issues such as decision making, policies, and support for teachers. Demographic information included gender, age, experience, and education. All of the above were presented in a forced choice format.

Open-ended questions were developed for the current study specific to the child's problems and strengths, the reason for referral to C.O.P.E., response of professionals to the child's needs. Also included were questions about the parent's awareness and use of community-based, school-based and medically-based resources.

2.3.4 CLC Specialist and School Principal Questionnaires

Questionnaires administered to CLC Specialists and school principals were designed to elicit information on schools' and Collaborative Learning Communities' (i.e., school districts) strategies and resources for management of students with social, emotional and learning problems (see Appendix C). Open-ended questions ask for information about the process and strategies for identifying students for discussion by the SRG, which school personnel are involved in the SRG, the way in which SRG meetings are conducted, how recommendations for further assessment of students are derived and carried out, and the ways that CLC Specialists, students and parents are involved in the process. Questions were also asked about how SRG recommendations are communicated to parents, and how implementation of the recommendations and student progress are monitored. Also queried was awareness and availability of services outside of the school for identification and treatment of students with emotional, behavioural and/or learning difficulties.

2.3.5 Archival Data

Archival data were sought on student achievement from CBE student records and on use of medical resources from Alberta Health Care records.

2.3.6 Case Study Data

Data from child, parent, teacher, and CLC Specialist surveys were triangulated with information from C.O.P.E. intervention files and additional parent interviews for the in-depth case studies. Questions guiding interviews with parents focused on their perception of the child's problems, how their child became involved in C.O.P.E., what transpired during the C.O.P.E. consultation(s), the impact of the process on the child, family and school and parents' opinions about what would have made C.O.P.E. more effective from their perspective.

2.3.7 C.O.P.E. Physician Interview

Questions were developed to study physician's perceptions of the implementation of C.O.P.E. as a new school-based system of care for diagnosing children with emotional, behavioural and/or learning problems (see Appendix D). Questions guiding in-depth interviews and focus groups with physicians probed for motivation for becoming involved with the study, impact of involvement on their professional practices, judgements of the C.O.P.E. process, outcomes and cost-effectiveness, and physicians' experiences in working with a team consisting of health care providers, teachers, and parents. Focus groups emphasized physicians' assessment of C.O.P.E. throughout the study period. Specific topics included advantages and disadvantages of the school-based system of care, program improvements, the effectiveness of school-based consultation on addressing the needs of children and families, and the possibility of using the C.O.P.E. model in the training of physicians.

2.3.8 C.O.P.E. Program Staff Interview

Questions guiding the in-depth interviews with the C.O.P.E. Coordinator and Family Liaison focused on their emerging role and responsibilities, how the C.O.P.E. process differed among intervention teams in the various CLCs, administrative obstacles and how these were overcome, program successes and areas for improvement.

2.4 Methodological Limitations

2.4.1 Sample Recruitment

Recruitment into the study group involved the need to establish strong linkages between the medical and educational communities in an environment in which these linkages were almost completely absent. A considerable amount of effort was required at early stages of program initiation to explain the purposes, mechanisms and expected outcomes of the program to school officials. In addition was the requirement to establish a presence of the C.O.P.E. program within each of the four CLCs selected for inclusion in the study group condition. Once established, these mechanisms proved highly beneficial to the program's success. However, the arrangements remained ad hoc throughout the study and continued attention from the C.O.P.E. Coordinator and Family Liaison was necessary to maintain functional relationships. For example, in the summer of 1999 growth in the enrollment of one of the schools designated as a locale for C.O.P.E. consultations was such that C.O.P.E. had to be relocated to another school.

Serious challenges were encountered in recruiting participants into the control groups, particularly in explaining to CLC Specialists and school principals the importance of control groups to the experimental research design. The intention was to compare results that ensued in the CLCs selected for the C.O.P.E. intervention to the status quo, defined as CLCs not selected for the C.O.P.E. intervention. However, the research program still required considerable time and effort on the part of school staff for identification of potential participants. A number of education officials appeared to view the inclusion of their school in a control group as depriving their students and staff of a needed resource (i.e., the C.O.P.E. program). Even though the research team suggested that until the research program had studied the effects of the intervention, the degree to which it is an important and effective resource could not be known, many schools were unable or unwilling to exert the effort required to assist with participant recruitment. Another concern expressed by many school staff hesitant to assist with recruitment was that participation in the control group may add undue stress and burden on already at risk parents and children and that the school would be left with the responsibility of dealing with any resulting difficulties on their own (i.e., without assistance from C.O.P.E.). Often, parents approached by schools to participate were also reluctant to become involved as control group participants as they were unable to appreciate any benefit to themselves or their children.

2.4.2 Sample Retention

Related to the issue of sample recruitment is sample retention. The research program was designed to measure change across time, and hence required the administration of survey questionnaires at several points during the program. For a number of parents, sustaining participation across 4- and 8-month intervals required considerable effort and this resulted in considerable data collection costs due to unkept appointments with research assistants. In an attempt to resolve this problem by minimizing the effort required of participating parents, telephone surveys were instituted in place of face-to-face surveys for parents for the 4- and 8-month parent interviews. Although this strategy reduced the data collection costs considerably, it was not entirely successful in reducing the number of unkept appointments or in increasing participation rates.

Families involved in the study appear to be highly transient with up to 30 percent of participating children changing schools at least once during the study time period. This often made it difficult to locate participants at the 4- and 8-month intervals.

2.4.3 Participants

Not surprisingly, many parent participants were unable to comprehend the distinction between research interviews and intervention consultations. As a consequence, research assistants were required to continually guard against responding to parent requests for advice and guidance and it was often challenging to keep the parent focused on and limit their answers to the research questions. It is also possible that parent perceptions of the willingness of "C.O.P.E." to help them may have been adversely effected.

Even though the Child Questionnaire was adapted in an attempt to make it comprehensible to children younger than the population for which the original *NLSCY* instrument was designed, it is possible that limited developmental capacity rendered responses unreliable or invalid. Also, the degree and type of problems experienced by children referred to C.O.P.E. may have interfered with their ability to comprehend and answer the questions asked of them.

There was frequent feedback from teachers complaining about the time needed to complete the questionnaire. A few objected to the demographic questions. Some responded that they did not know enough about the child to answer specific questions.

2.4.4 System-Level Events

Several issues relating to the school environment had a bearing on the research program. Intake of children into the C.O.P.E. program began in November and December 1998, with the first of the initial C.O.P.E. consultations occurring in January 1999. Significant recruitment and intake was occurring throughout the period of January through March 1999. However, a looming labour relations dispute between teachers and the CBE was also festering throughout this period, culminating in a vote by the teachers to take strike action in April. As the potential strike date approached, it became increasingly problematic to recruit into the C.O.P.E. study, or to expect the full cooperation of teachers and other educators as participants. In the end, a strike was narrowly averted due to actions of the Minister of Labour, and the research program resumed in earnest in late April.

In a move not unrelated to the budgetary difficulties that played a role in the labour dispute, the CBE realigned the configuration of CLC specialists in the summer of 1999. CLC specialists potentially play a significant role in providing assistance to schools in identifying children with social, emotional or learning problems. During the summer of 1999, the complement of three specialists per CLC was changed to two, and there also was some shuffling of personnel from one CLC to another. This change made measurement of the contribution of CLC specialists to the effectiveness of the C.O.P.E. intervention problematic.

Another challenge was the dismissal of all CBE Board members by the government in September 1999. System administrators who were good advocates for expanding or further enhancing C.O.P.E. were fully occupied by those broader issues during this period.

2.4.5 Missing Data

Logistical difficulties prevented the collection of archival data on student achievement from CBE student records. The narrative form taken for tracking student overall progress made it difficult to draw comparable data for students without extensive qualitative data analysis. Second, Provincial Achievement Test results for individual students are not consistently included in each child's Cumulative Student Record.

Privacy regulations made it more difficult to collect data on use of medical resources from Alberta Health Care records.

Several difficulties made it impossible to collect data from classroom teachers, school principals and CLC specialists at a second time interval. First was difficulty in obtaining timely responses from classroom teachers to the initial survey, a difficulty that stemmed in part from the amount of time required to complete the survey. Second was the necessity of extending intake into the study across two school years, in large part due to the difficulty encountered in recruiting participants into the control-groups. The consequences of this extension were that the school context experienced by children differed in non-systematic ways between the time of intake into the study and the completion of the study, making it impossible to make meaningful comparisons pre- and post-intervention.

3.0 RESULTS

The following is a summary of the quantitative data gathered through surveys administered to parents participating in the study.

3.1 Profile of Children in C.O.P.E. compared to a National Sample

The purpose of the C.O.P.E. program is to provide earlier identification and more effective treatment of children with emotional, behavioural and learning problems. The C.O.P.E. program focuses on the first part of this process – earlier identification – by introducing medical services (through a pediatrician and child psychiatrist) into a school consultation process that also includes the child, parent(s), teachers and other school resources (CLC specialists, principals or vice-principals). The expectation is that the children brought to this school-based diagnostic consultation will receive follow-up services either through the medical or educational system. However, the C.O.P.E. program itself was not designed in this initial pilot implementation, to provide such follow-up services.

The program began with the expectation that the children brought to the consultation would have exhibited emotional, behavioural, and/or learning problems. Furthermore, there was an expectation that the children brought to the C.O.P.E. consultation would differ from a random sample of Canadian children on various indicators of mental health. To test this expectation, a questionnaire that has been administered to a random sample of Canadian children and their parents; *The National Longitudinal Survey of Children and Youth (NLSCY)*, was administered in a revised format to the children in the C.O.P.E. program.

The *NLSCY* contains a number of indicators of children's mental health as measured by responses of parents to questions about the child's attitudes or behavior. In particular, it includes measures of such items as conduct disorder, hyperactivity, emotional disorder, anxiety, indirect aggression, physical aggression, inattention, and 'prosocial' behavior. Each of these characteristics is measured on the basis of a summary scale produced as an additive index of several discrete qualities. Since the C.O.P.E. study administered the same set of questions used in this segment of the *NLSCY*, it is possible to compare the responses of a random sample of Canadian children with the children in the C.O.P.E. study. This comparison appears in Table 3.1.

Table 3.1 involves a direct comparison between the Canadian national sample and the C.O.P.E. sample on the eight indicators noted above, with the comparison involving the individual attitudinal items. For example, according to the *NLSCY*, conduct disorder is a multidimensional behavioural attribute that is comprised of, and can be measured by responses to a set of questions, including:

- Destroys his/her own things
- Steals at home

- Gets into many fights
- Destroys things belonging to his/her family, or other children
- Is disobedient at school
- Tells lies or cheats
- Physically attacks people
- Vandalizes
- Is cruel, bullies or is mean to others
- Steals outside the home

In responding with respect to the behavior of their child, a parent could indicate that such behavior was 'never or not true', 'sometimes or somewhat true', or 'often or very true'. For each of the behavioural items, Table 3.1 includes the percentage responses for the Canadian sample in columns 1 to 3, and for the C.O.P.E. sample in columns 4 to 6.

Table 3.1 shows that on almost all of the indicators of mental health, the students in the C.O.P.E. program indicated consistently more negatively in comparison with the Canadian samples. For example, on the measure of conduct disorder for the Canadian sample, 16.7 percent of parents reported that it was 'sometimes or somewhat true' that their child destroys his/her own things, and a further 2.3 percent reported this was 'often or very true.' In sum, 19 percent of parents in the Canadian sample indicated some occasions when their child destroys their own things. For parents in the C.O.P.E. sample, 37 percent reported this was 'sometimes or somewhat true' and a further 15.6 percent reported it was 'often or very true.' Thus, over half (52.6 percent) indicated that this behavior was manifest by their child. Therefore, children in the C.O.P.E. program indicate higher incidence and frequency of this aspect of conduct disorder compared to the Canadian population.

Differences in the same direction, if not always the same magnitude, are evident with all nine other measures of conduct disorder. Children in the C.O.P.E. study were more likely to steal at home (26.2 percent versus 5.2 percent), get into fights (67.4 percent versus 33.7 percent), destroy things belonging to others (32.3 percent versus 11.2 percent), disobey at school (70.8 percent versus 21.6 percent), tell lies or cheat (71.7 percent versus 37.1 percent), physically attack people (51.9 percent versus 15.7 percent), vandalize (18.7 percent versus 2.5 percent), bully others (42.9 percent versus 11.1 percent), and steal outside the home (22.6 percent versus 2.0 percent).

The finding that the children in the C.O.P.E. study display lower levels of mental health as measured by reported conduct disorders itself, is not surprising. It was expected that children identified by their schools for participation in this program would indicate lower levels of mental health. What was more surprising was the magnitude of differences between the Canadian and the C.O.P.E. samples. Recalling that the C.O.P.E. program was limited to students in the regular classroom environment in Calgary's public school system, true magnitude of conduct disorders was surprising. It attests to the challenges facing the educational system in coping with children with significant mental health problems, particularly when many of those in the school system express concern about the lack of adequate resources to address the needs of such children.

The data on differences in conduct disorder between the Canadian sample and the C.O.P.E. sample are similar in direction to most of the other seven indicators of mental health. For example, the atypical quality of children in the C.O.P.E. program is much more apparent on the index measuring hyperactivity. On the statement that their child can't sit still, is restless or hyperactive, 19.1 percent of the Canadian sample indicated this was 'often or very true,' compared to 47.5 percent of the C.O.P.E. sample. Similarly, whereas 9.0 percent of the Canadian sample indicated their child was distractible or had difficulty sticking to an activity, the comparable percentage for the C.O.P.E. sample was 49.2 percent. Differences of a similar nature were found in response to questions about whether their child fidgets (15.6 percent versus 54.9 percent), can't concentrate for long (6.7 percent versus 46.9 percent), is impulsive (9.4 percent versus 48.6 percent), has difficulty awaiting turn in games or groups (12 percent versus 42.6 percent), and can't settle on things for more than a few moments (6 percent versus 21 percent).

Indeed, the data on hyperactivity in general, indicates more significant distinctiveness among children in the C.O.P.E. program compared to the Canadian sample. If anything, the children in C.O.P.E. are indicating a very high incidence of hyperactivity, and this quality appears to be a particularly distinctive feature of them being identified as having social, emotional or learning problems. The comparison with data at the Canadian level suggests that this feature is particularly characteristic of children being identified as "problems" within the school system.

Data on emotional disorder, measured in this study with seven indicators, shows patterns very similar to those regarding conduct disorder. For example, of the seven indicators of emotional disorder, among the Canadian population between 1 percent and 5.4 percent indicate this is 'often or very true.' In contrast, among the C.O.P.E. respondents, the similar percentage range is 6.1 percent to 30.4 percent, and in most cases ranges from about 16 percent to 20 percent. Perhaps more noticeable is the difference among the Canadian and C.O.P.E. sample who indicate that each attribute is either 'never' or 'not true.' Among the Canadian sample, the range on these seven items varies from 56 percent to 88 percent, whereas the comparable range for the C.O.P.E. sample is 20.5 percent to 62.4 percent. Taken as a whole, the data on emotional disorder demonstrate that children in the C.O.P.E. program were much more likely to indicate emotional disorder as compared to a sample of Canadians.

Data on anxiety also demonstrate a similar pattern. In the Canadian sample, typically 60 percent to 70 percent of respondents say that indications of anxiety are 'never' or 'not true' for their child, compared to 20 percent to 30 percent of the C.O.P.E. respondents. While the incidence of anxiety among respondents in the C.O.P.E. program is much greater than in the population as a whole, nonetheless, it appears to be manifest less frequently than hyperactivity. This is an expected finding given the age of the children seen through C.O.P.E., 5 – 12 years, since anxiety symptoms are more common in adolescence.

The indexes measuring indirect aggression and physical aggression are similar in indicating much higher incidence among the respondents in the C.O.P.E. program than in the population as a whole, although the differences in indirect aggression are not consistently as large as in other measures. Clearly, the children in the C.O.P.E. program display higher levels of both indirect and direct aggression than children in the Canadian population. Furthermore, it is likely that such tendencies are, at least in part, responsible for these children being identified as having social, emotional or learning difficulties.

The index measuring inattention displays patterns similar to those for hyperactivity. For example, more than 40 percent of the respondents in the C.O.P.E. program indicate their child often gives up easily, or can't concentrate, compared to only 7 percent for the Canadian population. Inattentiveness often appears related to other negative behaviors and thus the perceived inattentiveness of children in the C.O.P.E. program is likely an related to other problems. For example, children with anxiety disorders may have inattention or distractibility as presenting symptoms.

The last of the indexes included in Table 3.1 is 'prosocial behavior' and deserves special commentary for several reasons. Most obviously, it is ordered in a positive direction and differs from the other indicators of mental health. What is perhaps more striking with these responses is how similar the children in the C.O.P.E. program appear to be in comparison with the national sample. Although the data discussed previously indicate consistent differences with the C.O.P.E. children indicating more social, emotional and learning problems, the C.O.P.E. sample is nearly indistinguishable from the Canadian sample on their perceived kindness. Furthermore, it is noteworthy that despite perceiving their child as having identifiable problems and difficulties, these parents are no less likely to perceive their child's strengths and positive qualities. We shall see below further evidence to corroborate this finding on the perceived strengths of children in the C.O.P.E. program.

In summary, the data comparing children in a national sample with those in the C.O.P.E. program reveal a number of significant findings. Most noteworthy was the finding on consistent and significant differences in mental health between the two samples. On all measures, except prosocial behavior, children in the C.O.P.E. program demonstrate a much higher incidence of social, emotional and learning problems. These problems, and the difference from the national population, appear most pronounced with respect to hyperactivity and inattention, with substantial differences also on conduct and emotional disorder, anxiety and aggression. Indeed, what was perhaps most surprising was the overall magnitude of the problems with mental health in the public school system.

These observations provide the context for the evaluation of the effectiveness of the C.O.P.E. intervention. As discussed above, the C.O.P.E. program in the pilot phase was of relatively brief duration, lasting about 10 months in all. Many of the children entering the program indicated significant, and often multiple mental health problems. The C.O.P.E. program focused on a diagnostic approach (early identification), with no new resources to provide effective follow-up treatment. In addition, it required bringing together professionals from the educational system and the child mental health system; two systems of service with little prior experience of deep, mutually supportive, or ongoing collaboration. Despite these inherent problems, as we shall see below, the C.O.P.E. program has had a measurable positive impact on child mental health, and it is to this analysis that we now turn.

TABLE 3.1
Comparison of Reported Attitudes and Behaviors of Children in a National Sample and the C.O.P.E. Sample

	NATIONAL STUDY (%)			C.O.P.E. STUDY (%)		
	Never or not true	Sometimes or somewhat true	Often or very true	Never or not true	Sometimes or somewhat true	Often or very true
Conduct Disorder						
Destroys his/her own things?	81.0	16.7	2.3	47.3	37.0	15.6
Steals at home?	94.9	4.5	0.7	73.8	20.9	5.3
Gets into many fights?	66.3	29.5	4.2	32.6	43.8	23.6
Destroys things belonging to her/his family, or other children?	88.8	10.5	0.7	67.6	26.2	6.1
Is disobedient at school?	78.2	20.5	1.1	29.2	47.9	22.9
Tells lies or cheats?	62.9	35.0	2.1	28.3	53.3	18.4
Physically attacks people?	84.3	14.5	1.2	48.1	39.1	12.8
Vandalizes?	97.5	2.3	0.2	80.7	16.5	2.5
Is cruel, bullies or is mean to others?	89.0	10.4	0.7	55.1	38.4	6.5
Steals outside the home?	97.9	1.9	0.1	77.4	18.0	4.6
Hyperactivity						
Can't sit still, is restless or hyperactive?	39.5	41.4	19.1	14.5	38.0	47.5
Is distractible, has trouble sticking to an activity?	52.5	38.5	9.0	13.9	36.9	49.2
Fidgets?	45.3	39.1	15.6	18.0	27.0	54.9
Can't concentrate, can't pay attention for long?	57.8	35.5	6.7	11.1	42.0	46.9
Is impulsive, acts without thinking?	43.5	47.2	9.4	9.4	42.0	48.6
Has difficulty awaiting turn in games or groups?	45.7	42.3	12.0	21.7	35.7	42.6
Cannot settle to anything for more than a few moments?	64.9	29.1	6.0	30.0	49.0	21.0
Emotional Disorder						
Seems to be unhappy, sad or depressed?	71.9	27.0	1.1	20.6	63.0	16.5
Is not as happy as other children?	88.0	10.1	1.8	43.8	40.1	16.1
Is too fearful or anxious?	65.3	30.6	4.1	30.6	43.7	25.7
Is worried?	56.6	39.0	4.4	20.5	49.2	30.4
Cries a lot?	60.5	34.1	5.4	34.2	45.3	20.6
Is nervous, high-strung or tense?	75.4	21.3	3.3	40.6	40.2	18.9
Has trouble enjoying him/herself?	84.8	14.2	1.0	62.4	31.0	6.1

Table 3.1 Continued...

	NATIONAL STUDY (%)			C.O.P.E. STUDY (%)		
	Never or not true	Sometimes or somewhat true	Often or very true	Never or not true	Sometimes or somewhat true	Often or very true
Anxiety						
Seems to be happy, sad or depressed?	71.9	27.0	1.1	20.6	63.0	16.5
Is too fearful or anxious?	65.3	30.6	4.1	30.6	43.7	25.7
Is worried?	56.6	39.0	4.4	20.5	49.2	30.4
Tends to do things on his/her own – is rather solitary?	31.2	49.0	19.7	13.9	46.3	39.8
Cries a lot?	60.5	34.1	5.4	34.2	45.3	20.6
Appears miserable, unhappy, tearful or distressed?	75.5	23.1	1.3	36.4	51.7	12.0
Indirect Aggression						
When mad at someone, tries to get others to dislike that person?	81.5	16.6	1.9	60.3	27.4	12.4
When mad at someone, becomes friends with another to get revenge?	82.1	16.3	1.6	73.2	19.6	7.2
When mad at someone, says bad things behind the other's back?	73.0	25.1	1.9	50.0	28.6	21.4
When mad at someone, says to others, "Let's not be with him/her?"	69.9	28.1	2.0	49.8	39.6	10.2
When mad at someone, tells other one's secrets to a third person?	79.7	18.8	1.5	72.2	21.5	6.3
Physical Aggression						
Gets into many fights?	66.3	29.5	4.2	32.6	43.8	23.6
When other child accidentally hurts him/her assumes that the other child meant to do it, and reacts with anger and fighting?	63.9	29.9	6.3	27.3	40.0	32.7
Physically attacks people?	84.3	14.5	1.2	48.1	39.1	12.8
Kicks, bites, hits other children?	80.0	18.7	1.3	50.4	38.1	11.5

Table 3.1 Continued...

	NATIONAL STUDY (%)			C.O.P.E. STUDY (%)		
	Never or not true	Sometimes or somewhat true	Often or very true	Never or not true	Sometimes or somewhat true	Often or very true
Inattention						
Can't concentrate, can't pay attention for long?	57.8	35.5	6.7	11.1	42.0	46.9
Gives up easily?	55.3	37.6	7.0	21.6	37.1	41.2
Stares into space?	78.0	20.1	1.9	50.6	37.4	11.9
Is attentive?	61.6	35.2	3.2	14.3	66.4	20.4
Prosocial Behaviour						
Shows sympathy to someone who has made a mistake?	6.1	46.3	47.7	8.2	48.1	43.6
Will try to help someone who has been hurt?	6.0	34.7	59.3	4.6	29.5	66.0
Volunteer to help clear up a mess someone else has made?	30.3	50.5	19.2	44.0	42.0	14.0
If there is a quarrel or dispute, will try to stop it?	26.0	54.8	19.2	38	45.0	16.9
Offers to help other children who are having difficulty with a task?	8.8	47.5	43.7	11.3	46.9	41.8
Comforts a child who is crying or upset?	6.3	45.0	48.7	7.8	38.3	53.9
Spontaneously helps to pick up objects which another child has dropped?	20.1	57.1	22.8	33.9	45.3	20.8
Will invite bystanders to join in a game?	13.7	55.6	30.7	18.7	45.2	36.1
Helps other children who are feeling sick?	10.0	52.4	37.7	11.6	42.9	45.5
Takes the opportunity to praise the work of less able children?	26.2	48.8	25.0	21.8	47.1	31.1

3.2 Program Impact on Perceived Problems

Table 3.2 examines parental reports of changes in perceived problems experienced by the children 4 months following the initial interview, and 8 months following the initial interview. The data in the table compare responses of those whose children were in the study group, and hence who participated in the C.O.P.E. program, and those in the control group, who did not participate in the C.O.P.E. program but were included in the study.

Panel A of Table 3.1 presents the results after 4 months. Of those who participated in the C.O.P.E. program, 16.9 percent indicated that their children were manifesting either more or new problems 4 months into the program, compared to the program outset. Slightly over one-fifth (22.5 percent) reported no change in their child's problems, and a full three-fifths (60.6 percent) perceived that their child experienced fewer problems. Among the control group at the four-month interval, 27 percent perceived more problems, 27 percent perceived no change, and slightly less than half (44.9 percent) perceived that their child had fewer problems. Among those perceiving their child had fewer problems, the difference between those who had the C.O.P.E. intervention and those who did not was 15.7 percent. Although this difference proved not to be statistically significant at the 0.05 level, it is highly suggestive of an impact of the C.O.P.E. program.

When the analysis is extended to an 8-month period, the trends become less clear-cut. As Panel B suggests, students in the C.O.P.E. program appeared to continue to benefit from the program over the 8 month period, with those experiencing fewer problems increasing from 60.6 percent to 72.1 percent. However, the percentage of parents in the control group perceiving fewer problems also increased, from 45.9 percent after 4 months, to 69.6 percent after 8 months. This latter figure should be interpreted with caution for several reasons. First, the number of cases on which it is based (N=23) is so small that the percentage data are subject to a large margin of error. In addition, as we will suggest below, among the control group of respondents, there is a high degree of inconsistency between reported summary assessments of change, and assessments of change based on additive scales, thereby raising concerns about the reliability of the summary scores among the control group.

A further indication of parental assessment of the positive impact of the C.O.P.E. program can be seen in Panel C of Table 3.2 and in Table 3.3. Panel C reports parents' assessment of the overall experience of their child 4 months and 8 months after beginning the C.O.P.E. program. Of these parents, 63.2 percent reported after 4 months that things were better for their child, a figure that increased to 70.2 percent, 8 months following initial entry into the program.

These positive assessments are affirmed in response to the questions in Table 3.3. Over two-thirds of parents (67.4 percent) thought that having the doctor at the school was a positive thing compared to only 3.7 percent who thought it was negative. Similarly, over 7 in 8 respondents (86.5 percent) said they preferred that the doctors came to the school compared to only 7.9 percent who preferred that they not come to the school. In addition, bringing the doctors into the school appears to provide parents with additional information with respect to other services available within the educational, health care or social services systems available in Calgary. For example, almost half the respondents (44.7 percent) said they became more aware of services available for their child, almost all of whom (40.5 percent) indicated that as a result of this increased knowledge, they were more likely to access the additional services.

One must understand this latter finding in context. The C.O.P.E. program is focussed largely on diagnosis, rather than on service provision or service delivery. In the current iteration of the C.O.P.E. program, the direct linkages between C.O.P.E. and a broader system of care for children with social, emotional and/or learning problems was at best in a very nascent stage, and was largely undeveloped. Despite this fact, the survey data seem to suggest that a number of parents of children in the program appeared to gain some important skills in navigating the complex web of support services. While the program was far from able universally to provide such skills (and some of the impressionistic data from interviews indicated that many of the parents of the children in the C.O.P.E. program were, themselves, likely sufferers from emotional, behavioural or learning problems), nonetheless, it appears to have provided an important starting point for many.

Further to this issue, the data from the C.O.P.E. research program supports the hypothesis that the program provides significant learning for parents, not only with respect to their ability to seek and find support services, but also to better understand the problems their child is experiencing – that is, to improved diagnosis. For example, we developed a number of scales of such items as hyperactivity, conduct disorder, emotional disorder, anxiety, indirect aggression, physical aggression, and inattention (from Table 1), and compared reported changes on these discrete scales with the summary scores on reported problems that were reported in Table 1. The findings for this analysis are that almost without exception, the changes in scores across the scales were consistent and statistically significant with the summary scores for the parents of children in the C.O.P.E. program, and inconsistent and not statistically significant for the control group. The data for this analysis are in Tables 3.4 to 3.11

Table 3.2
Parental Attitudes Towards Child Problems and the C.O.P.E. Program

Panel A: Parent Reported Change in Problems Four Months into Program

	Study Group	Control Group	Total
More or New Problems	16.9% (27)	27.0% (10)	18.8% (37)
Same/No Change	22.5% (36)	27.0% (10)	23.4% (46)
Less Problems	60.6% (97)	45.9% (17)	57.9% (114)
Total	100.0% (160)	100.0% (37)	100.0% (197)

Panel B: Parent Reported Change in Problems Eight Months into Program

	Study Group	Control Group	Total
More or New Problems	19.8% (22)	21.7% (5)	20.1% (27)
Same/No Change	8.1% (9)	8.7% (2)	8.2% (11)
Less Problems	72.1% (80)	69.6% (16)	71.6% (96)
Total	100% (111)	100% (23)	100% (134)

Panel C: Overall Experience Reported by Parent at Four and Eight Months

Taking into account your overall experience since your child first met the doctor(s) at the school, are things any better, about the same or worse for your child? *

	Study Group at Four Months	Study Group at Eight Months
Better	63.2% (79)	70.0% (21)
Same	30.4% (38)	26.7% (8)
Worse	4.8% (6)	0.0% (0)
Some Better/Some Worse/Some Same	1.6% (2)	3.3% (1)
Total	100% (125)	100% (30)
Missing	(70)	(165)

**There were many respondents that did not answer this question and it was not asked for the control group respondents, so it is not as useful as the change in problems question. However, it is a positive result.*

Table 3.3

Parental Attitudes Towards the C.O.P.E. Program

Do you think having the doctor at the school to meet with the teachers, you and your child was a good thing and made a positive impact, didn't have much impact, or was a bad thing and had a negative impact?

Positive	No Impact	Negative	Some Positive	Don't Know	(N)
67.4%	26.7%	3.7%	0.7%	1.5%	(135)

If you knew at the start what you know now, would you rather have the doctors some to school like this, or would you rather have it the way it was before, when the doctors didn't come to the school?

Come to School	Didn't Come to School	Don't Know	Doesn't Matter	(N)
86.5%	7.9%	0.8%	4.8%	(126)

As a result of the meeting with the doctors, are you more aware of services available in Calgary for you and your child, or has it not made a difference on your level of awareness?

More Aware	No Difference	(N)
44.7%	55.3%	(141)

As a result of the meeting with the doctor(s), are you more likely to use services available to your child, or has it not made a difference in your use of services?

More Likely	No Difference	Don't Know	(N)
40.5%	58.8%	0.8%	(131)

Tables 3.4 to 3.11 compare parents responses to the general question of whether their child is experiencing more problems, fewer problems, or the same number of problems with their responses on the summary measures of specific mental health indicators. It was expected that if the C.O.P.E. program were successful, it would better equip parents with the ability to provide a more accurate assessment of their child's state of mental health. That is, better diagnosis on the part of the C.O.P.E. medical team, undertaken in a consultation at which one or both of the parents are present and involved, should provide significant learning for the parent as well as improved diagnosis. An indication of such learning is that the parents should display a higher correspondence between a generalized impression of change among their child, and an indicator of specific change. In Tables 3.4 to 3.11, the program effect can be discerned by comparing children in the C.O.P.E. program with children in the control group.

As an indication of how to read these data, we can examine data on conduct disorder in Table 3.6. Examining students in the C.O.P.E. intervention group, note that at time 1, intake into the program, conduct disorder was 1.57 among parents who reported more problems after 4 months, and 1.62 among those reporting fewer problems. At time 2, four months into the C.O.P.E. program, the conduct disorder score increased to 1.68 among those reported more problems generally, and it decreased to 1.38 among those reporting fewer problems. Thus, the changes on the specific item of conduct disorder were consistent with changes on the general question. Furthermore, note that the change in the reported scores was significant at the .01 level.

This trend does not hold, however, for parents of children in the control group. On the conduct disorder scales, parents reporting that their child experienced more problems generally, actually reported a decline in conduct disorder (1.51 to 1.39) of a magnitude that was greater than those reporting fewer problems (1.53 to 1.44). Thus, for the control group, reported change generally was unrelated to reported change on the specific item.

This finding with respect to the correspondence between reported change generally, and reported change in specific dimensions, can be seen on the hyperactivity index (Table 3.5), emotional disorder (Table 3.7), anxiety (Table 3.8), indirect aggression (Table 3.9), and physical aggression (Table 3.10). The pattern does not hold on the score of inattention (Table 3.11), largely it would appear, because of the very modest amount of change in the scores on inattention between the time 1 and time 2 data (2.04 versus 1.97).

The pattern also does not hold for changes in prosocial behavior, as can be seen in Table 3.4. Although in this instance the direction of the relationships is as predicted, it does not achieve statistical significance. Recall the data in Table 3.1, which showed that the children in the C.O.P.E. sample differed from the national sample in all cases except the indicators of prosocial behavior. If the children in C.O.P.E. do not differ from children overall on this dimension, then it would not be expected that the C.O.P.E. intervention would have an effect on their behavior on this item. Thus, the lack of a statistically significant relationship in this case is consistent with the expectations from the analysis.

In summary, data in Tables 3.4 to 3.11 indicating the correspondence between reported changes in child's mental health and changes on specific indicators of mental health are important for several reasons. First, the changes for children in the C.O.P.E. program were, with few exceptions, in the anticipated direction. Reports of either improved or deteriorating behaviors on specific items corresponded to reports of general improvement or deterioration. For the control group, there was no correspondence whatsoever. This indicates that parents in the C.O.P.E. program are better able to recognize specific behavioural changes associated with particular mental health indicators. Furthermore, this finding suggests important learning among the parents, and improved diagnosis – that is, more accurate and effective early identification – for children in the C.O.P.E. program. Thus, these data confirm the primary hypothesis on which the program was designed and implemented.

The data also suggest a high degree of unreliability in reports of generally improved or deteriorating performance among the children in the control group. There was no significant relationship between parents' perception of improvements on the general question and their perceptions of improvements on the specific items. Thus, this would indicate a lack of effective diagnosis, and little learning on the part of parents as to how to identify their child's difficulties and how to respond to them. Therefore, despite the reports of improvements in the child's performance after 4 and 8 months in the control group, it is not apparent that specific improvement has occurred, nor that the parents are equipped to identify such improvement. This leads to the conclusion that the data likely are highly unreliable and unstable.

Table 3.4

Parental Report of Change in PROSOCIAL BEHAVIOUR

Study Group

		Prosocial Behaviour: Time 1	Prosocial Behaviour: Time 2	Change in Prosocial Behaviour over 4 months
More/New	Mean	2.2303	2.1860	4.430E-02
	N	27	27	27
	Std.Deviation	.4034	.2820	.3495
Less	Mean	2.1808	2.2631	-8.3552E-02
	N	96	97	96
	Std.Deviation	.4346	.4045	.3928
Same	Mean	2.1715	2.2456	-9.5437E-02
	N	36	35	34
	Std. Deviation	.4736	.3801	.2330
Total	Mean	2.1871	2.2462	-6.4139E-02
	N	159	159	157
	Std. Deviation	.4368	.3800	.3582
Significance*		.850	.650	.222

Control Group

		Prosocial Behaviour: Time 1	Prosocial Behaviour: Time 2	Change in Prosocial Behaviour over 4 months
More/New	Mean	2.4506	2.3186	.1320
	N	10	10	10
	Std. Deviation	.8042	.4081	.8576
Less	Mean	1.9726	2.1473	-.1747
	N	17	17	17
	Std. Deviation	.4048	.3923	.3008
Same	Mean	1.9710	2.0333	-6.2346E-02
	N	9	9	9
	Std. Deviation	.3349	.3775	.3965
Total	Mean	2.1050	2.1664	-6.1409E-02
	N	36	36	36
	Std. Deviation	.5604	.3964	.5323
Significance		.068	.290	.382

*Significance value for Tables 3.4 to 3.11 are based on F value for Analysis of Variance

TABLE 3.5

Parental Report of Change in HYPERACTIVITY DISORDER

Study Group

		Hyperactivity: Time 1	Hyperactivity: Time 2	Change in Hyperactivity over 4 months
More/New	Mean	2.4127	2.3959	1.675E-02
	N	27	27	27
	Std. Deviation	.4008	.4264	.3841
Less	Mean	2.2442	1.9897	.2471
	N	96	97	96
	Std. Deviation	.5407	.4775	.4892
Same	Mean	2.1706	2.1469	3.782E-02
	N	36	35	34
	Std. Deviation	.4643	.4537	.3841
Total	Mean	2.2561	2.0933	.1622
	N	159	159	157
	Std. Deviation	.5059	.4854	.4615
Significance		.160	.000	.014

Control Group

		Hyperactivity: Time 1	Hyperactivity: Time 2	Change in Hyperactivity over 4 months
More/New	Mean	2.3500	2.3524	-2.3810E-03
	N	10	10	10
	Std. Deviation	.5537	.4354	.4980
Less	Mean	2.2773	2.1008	.1765
	N	17	17	17
	Std. Deviation	.4417	.4595	.3994
Same	Mean	2.3619	2.2381	.1238
	N	9	9	9
	Std. Deviation	.5222	.5487	.4167
Total	Mean	2.3187	2.2050	.1136
	N	36	36	36
	Std. Deviation	.4816	.4752	.4268
Significance		.893	.414	.587

Table 3.6

Parental Report of Change in CONDUCT DISORDER

Study Group

		Conduct Disorder: Time 1	Conduct Disorder: Time 2	Change in Conduct Disorder over 4 months
More/New	Mean	1.5667	1.6842	-.1175
	N	27	27	27
	Std. Deviation	.3311	.3648	.3170
Less	Mean	1.6176	1.3774	.2392
	N	96	97	96
	Std. Deviation	.3885	.3165	.3983
Same	Mean	1.4555	1.4223	4.762E-02
	N	36	35	34
	Std. Deviation	.3482	.3844	.1991
Total	Mean	1.5723	1.4393	.1363
	N	159	159	157
	Std. Deviation	.3742	.3567	.3756
Significance		.085	.000	.000

Control Group

		Conduct Disorder: Time 1	Conduct Disorder: Time 2	Change in Conduct Disorder over 4 months
More/New	Mean	1.5018	1.3909	.1109
	N	10	10	10
	Std. Deviation	.3701	.3430	.1837
Less	Mean	1.5332	1.4385	9.465E-02
	N	17	17	17
	Std. Deviation	.3725	.2751	.3426
Same	Mean	1.5758	1.4444	.1313
	N	9	9	9
	Std. Deviation	.3083	.4226	.3553
Total	Mean	1.5351	1.4268	.1083
	N	36	36	36
	Std. Deviation	.3480	.3258	.3024
Significance		.903	.923	.960

Table 3.7

Parental Report of Change in EMOTIONAL DISORDER

Study Group

		Emotional Disorder: Time 1	Emotional Disorder: Time 2	Change in Emotional Disorder over 4 months
More/New	Mean	1.8836	2.0882	-.2046
	N	27	27	27
	Std. Deviation	.4869	.4484	.3481
Less	Mean	1.8906	1.6112	.2819
	N	96	97	96
	Std. Deviation	.6813	.4366	.6858
Same	Mean	1.7328	1.7318	-2.3669E-02
	N	36	35	34
	Std. Deviation	.3324	.7474	.8640
Total	Mean	1.8537	1.7188	.1321
	N	159	159	157
	Std. Deviation	.5890	.5473	.7094
Significance		.377	.000	.002

Control Group

		Emotional Disorder: Time 1	Emotional Disorder: Time 2	Change in Emotional Disorder over 4 months
More/New	Mean	1.9857	1.9143	7.143E-02
	N	10	10	10
	Std. Deviation	.4336	.5225	.4629
Less	Mean	1.8403	1.7731	6.723E-02
	N	17	17	17
	Std. Deviation	.4486	.5202	.3118
Same	Mean	1.9180	1.8915	2.646E-02
	N	9	9	9
	Std. Deviation	.4840	.4466	.3393
Total	Mean	1.9001	1.8419	5.820E-02
	N	36	36	36
	Std. Deviation	.4398	.4939	.3553
Significance		.714	.739	.955

TABLE 3.8

Parental Report of Change in ANXIETY DISORDER

Study Group

		Anxiety: Time 1	Anxiety: Time 2	Change in Anxiety over 4 months
More/New	Mean	2.0494	2.1543	.1049
	N	27	27	27
	Std. Deviation	.5025	.4890	.3425
Less	Mean	2.0521	1.8101	.2439
	N	96	97	96
	Std. Deviation	.6958	.4133	.7177
Same	Mean	1.8764	1.9438	-.1025
	N	36	35	34
	Std. Deviation	.3560	.8717	.9779
Total	Mean	2.0118	1.8980	-.1069
	N	159	159	157
	Std. Deviation	.6049	.5884	.7513
Significance		.313	.017	.018

Control Group

		Anxiety: Time 1	Anxiety: Time 2	Change in Anxiety over 4 months
More/New	Mean	2.1167	2.0333	8.333E-02
	N	10	10	10
	Std. Deviation	.3772	.4957	.4321
Less	Mean	2.0000	1.9804	1.961E-02
	N	17	17	17
	Std. Deviation	.4249	.5385	.3627
Same	Mean	1.8481	1.8889	-4.0741E-02
	N	9	9	9
	Std. Deviation	.4676	.5000	.3265
Total	Mean	1.9944	1.9722	2.222E-02
	N	36	36	36
	Std. Deviation	.4230	.5047	.3669
Significance		.395	.829	.772

Table 3.9

Parental Report of Change in INDIRECT AGGRESSION

Study Group

		Indirect Aggression: Time 1	Indirect Aggression: Time 2	Change in Indirect Aggression over 4 months
More/New	Mean	1.4926	1.7043	-.2117
	N	27	27	27
	Std. Deviation	.3605	.5772	.5958
Less	Mean	1.5943	1.3706	.2198
	N	96	97	96
	Std. Deviation	.7191	.4188	.6965
Same	Mean	1.3819	1.4157	2.082E-17
	N	36	35	34
	Std. Deviation	.4793	.4870	.4919
Total	Mean	1.5289	1.4372	9.798E-02
	N	159	159	157
	Std. Deviation	.6252	.4769	.6585
Significance		.210	.005	.006

Control Group

		Indirect Aggression: Time 1	Indirect Aggression: Time 2	Change in Indirect Aggression over 4 months
More/New	Mean	1.5300	1.3200	.2100
	N	10	10	10
	Std. Deviation	.3268	.2530	.1912
Less	Mean	1.5059	1.3941	.1118
	N	17	17	17
	Std. Deviation	.5105	.4279	.3998
Same	Mean	1.6000	1.3058	.2944
	N	9	9	9
	Std. Deviation	.4796	.4187	.3167
Total	Mean	1.5361	1.3514	.1847
	N	36	36	36
	Std. Deviation	.4479	.3767	.3336
Significance		.883	.819	.409

Table 3.10

Parental Report of Change in PHYSICAL AGGRESSION

Study Group

		Physical Aggression: Time 1	Physical Aggression: Time 2	Change in Physical Aggression over 4 months
More/New	Mean	1.7222	1.9907	-.2685
	N	27	27	27
	Std. Deviation	.5111	1.1061	1.0329
Less	Mean	1.9036	1.5275	.3733
	N	96	97	96
	Std. Deviation	.5808	.4511	.5411
Same	Mean	1.7604	1.5571	.1434
	N	36	35	34
	Std. Deviation	.6207	.5691	.4929
Total	Mean	1.80404	1.6127	.2131
	N	159	159	157
	Std. Deviation	.5809	.6513	.6816
Significance		.231	.004	.000

Control Group

		Physical Aggression: Time 1	Physical Aggression: Time 2	Change in Physical Aggression over 4 months
More/New	Mean	1.6250	1.5167	.1083
	N	10	10	10
	Std. Deviation	.4602	.4888	.2578
Less	Mean	1.7941	1.7647	2.941E-02
	N	17	17	17
	Std. Deviation	.5172	.5189	.5512
Same	Mean	1.7222	1.7500	-2.7778E-02
	N	9	9	9
	Std. Deviation	.4751	.4841	.6052
Total	Mean	1.7292	1.6921	3.704E-02
	N	36	36	36
	Std. Deviation	.4832	.5003	.4922
Significance		.692	.438	.839

Table 3.11

Parental Report of Change in INATTENTION

Study Group

		Inattention: Time 1	Inattention: Time 2	Change in Inattention over 4 months
More/New	Mean	2.1605	2.1481	1.235E-02
	N	27	27	27
	Std. Deviation	.3202	.3485	.3638
Less	Mean	2.0078	1.9158	9.028E-02
	N	96	97	96
	Std. Deviation	.3725	.3537	.4337
Same	Mean	2.0440	1.9762	8.578E-02
	N	36	35	34
	Std. Deviation	.3670	.2826	.3108
Total	Mean	2.0419	1.9686	7.590E-02
	N	159	159	157
	Std. Deviation	.3850	.3470	.3973
Significance		.158	.008	.661

Control Group

		Inattention: Time 1	Inattention: Time 2	Change in Inattention over 4 months
More/New	Mean	2.0250	2.1500	-.1250
	N	10	10	10
	Std. Deviation	.5197	.3375	.4602
Less	Mean	2.0294	3.0441	-1.4706E-02
	N	17	17	17
	Std. Deviation	.3047	.3335	.4146
Same	Mean	2.0278	2.0278	.0000
	N	9	9	9
	Std. Deviation	.4229	.2635	.4146
Total	Mean	2.0278	3.0694	-4.1667E-02
	N	36	36	36
	Std. Deviation	.3909	.3140	.4247
Significance		1.00	.642	.774

3.3 Challenges, Successes and Crosscutting Themes in Program Implementation

The following is a preliminary analysis and summary of the key issues that emerged from the interviews and focus groups with physicians and the C.O.P.E. administration, interviews conducted with six parents, and feedback from various stakeholders.

One of the key challenges for the C.O.P.E. program was to build a system of care that brought together two very different systems – health and education, each with its own mandate, policy and procedures, and its own professional culture. The problems and tensions in both systems are reflected in the issues discussed below.

3.3.1 Physicians' Perspectives

3.3.1.1. Reimbursement for Services

The compensation for the time and services provided by both physicians and teachers has been problematic in the C.O.P.E. project due to factors inherent in the billing structure established by the government. For example, some C.O.P.E. physicians are compensated at a lower rate than they would be if they saw the child in their private practice. This is the result of the Alberta provincial government's guidelines for billing. Pediatricians, are much more limited in the kinds of things they can bill for, whereas psychiatrists can bill for a broader range of consultation activities, which creates inequities on the C.O.P.E. medical team. For example, pediatricians cannot bill for consultations if the child is not present and psychiatrists can. If the pediatrician and the psychiatrist are meeting to discuss a child, the pediatrician can bill for only part of the time (because the child is not present), and the psychiatrist can bill for the whole time of the consultation. In addition, psychiatrists must have a referral from a family doctor in order to bill for seeing a child, while a pediatrician does not needs this referral. Many families referred to C.O.P.E. have nominal access to health care, and tend to use walk in clinics and hospital emergency room services. Few of these families would have a primary care physician.

Early planning is now ongoing to make C.O.P.E. a demonstration site for an alternate payment plan for physicians. Physicians would be paid on an hourly basis to provide direct service and participate in more global intervention programs.

Teachers also have to give up classroom time to attend a consultation meeting that may be held at different school sites. The home school has to provide substitute costs to cover the time the teacher is away at the meeting. The teacher must also prepare for the time s/he is away, resulting in an increase to his or her workload.

Another limitation imposed by a rigid mechanism for billing for physician's time, is the opportunity for health care providers who are part of the C.O.P.E. Team to provide public education sessions for teachers, parents, and other community members to address the myths and realities of children with behavior and emotional difficulties. In the original conception of the C.O.P.E. program the intent was to have the physicians conduct school based in-service sessions to enhance the knowledge and skill set of school-based personnel to identify and address the needs of children with behavioural, emotional and learning difficulties. Through these sessions the physicians could compliment what teachers and specialist observe and learn through their involvement in the consultation with students and parents. Information sessions and workshops would provide the opportunity for school-based personnel to extend their understanding, engage in professional dialogue with health care providers, and discuss strategies and services for these children. This educative component ought to be an integral part of building a system of care, and integrating two systems of care: health and education.

3.3.1.2 Professional Obligation

An important characteristic of C.O.P.E. is that it does not operate as a free standing clinic that is housed in a school, nor is it based on an out-patient mental health model; rather, it is a collaborative approach to the early identification of children with social, emotional and learning difficulties. Unlike a clinical setting, where the physicians see families in their office, in C.O.P.E. the physicians are presented cases for consideration by teachers, and school administrators. There is often a sense of urgency or immediacy to attending to the needs of the child in the case presented because it is no longer only the parents advocating for the child, but also those who have to deal with the child outside of the family setting. Therefore, whether or not the case is suitable for C.O.P.E. there is an immediate opportunity to engage in a discussion between the health care providers and school-based personnel (teachers, administrators and CLC specialist) regarding appropriate courses of action for the child. In addition, because the C.O.P.E. team returns to the school on a regular basis there is an opportunity for school based personnel to re-visit cases and to continue to advocate for these children. This situation contributes to the physicians' heightened sense of professional responsibility for ensuring that the needs of these children are addressed (see Appendix H for illustrative case studies).

As a consequence, some physicians are of the view that it is difficult for them to be a "consulting only" practice, while others have little problem with this role. All physicians agree that there is no conflict in the initial consultation in which the school presents various cases to C.O.P.E., and at this point the physicians determine if the case would be suitable for C.O.P.E., or if the child's needs could be better met through alternative resources. Sometimes the physician that screens the cases may not be the consulting physician that sees the family. Where the conflict occurs is when the physician sees a family at the second consultation and realizes the urgency and/or complexity of the case. S/he has a professional obligation or "duty of care" to ensure that the child receives the appropriate treatment. In some cases the family may not have a family physician and uses only emergency or walk-in clinics, or there is no immediate access to the next level of care, the physician feels obligated to treat the child. Therefore the physician feels an obligation to accept the family into their already crowded private practice, or to provide some treatment and follow-up.

One of the benefits of having school-based collaborative consultations is that there appears to be a shared understanding of the difficulties children are presenting, and a heightened sense of responsibility for ensuring these children have their needs addressed.

At the heart of the problem is that the health care system is congested with long waiting lists for health specialists, creating time lapses before the family can access the appropriate medical services, programs or treatment in the broader community. The problem is confounded by the "medicalization" of social problems that could be dealt with more appropriately though a social welfare caseworker or family therapist. There is a clear need for a "Treatment Team" that is based in the various communities that can respond more immediately and comprehensively to the needs identified through C.O.P.E.

3.3.1.3 Confidentiality of Information

C.O.P.E. provides an opportunity to bring all of the stakeholders involved in addressing the emotional, behavioural and learning needs of the child together at one time. Through this process physicians have access to information and different perceptions of the presenting problem. The result is a more comprehensive understanding of the child in the home and school setting. The school space is often more accessible and less threatening to the family and child than a hospital or clinical setting. However, the C.O.P.E. physician must also be very skilled in dealing with the disclosure of sensitive information in the group setting. They need to be skilled at providing the opportunity for the family to have private time with the physician in a group consultation, where it may not be appropriate for the school based personnel to be present when such information is being disclosed.

Confidentiality of records becomes another problem when information needs to flow between different agencies. There is a heightened sensitivity among the physicians regarding what information to include in letters and reports that are shared among agencies and with the parents. Schools keep confidential cumulative records on each child that the physicians have access to; however, only selected information attained in the C.O.P.E. consultation becomes part of that file. The C.O.P.E. team also keeps a separate medical file for each child.

To enhance better communication among parents, school-based personnel, and the C.O.P.E. team, and to ensure that parents and the school attend to the recommendations made by C.O.P.E. physicians, the Family Liaison makes duplicate copies of the recommendations made by the C.O.P.E. team. With permission from the family, s/he ensures that all three groups receive a copy. The Family Liaison contacts the family one week later to review the recommendations and if necessary assist the family in implementing the recommendations.

3.3.1.4 Adapting the Medical Role to the School Setting

Schools in Canada have not had a history of including school based medical services beyond the traditional "school nurse" services. An important component of the success of this program has been its ability to provide a group of highly respected physicians as a resource to the intervention schools. The broader system has stood by not understanding why busy senior physicians would volunteer their time and accept a lower rate of compensation to be part of the C.O.P.E. team.

It would appear that the physician team is motivated to work in the school environment largely because they are able to intervene earlier in the identification of children with behavioural and emotional needs with the intent that early identification and intervention may prevent the evolution of more serious problems in adolescence and adulthood. These physicians may be characterized as mavericks in the health care system. They are team players who have to be flexible in their approach to professional practice, are knowledgeable regarding child development and learning, are committed to preventative medicine, have good knowledge of the various pathways to resources in the community and health care system, have a sense of humor and demonstrate excellent interpersonal skills. The complexity and lack of predictability of the kinds of cases presented through C.O.P.E. requires these physicians to function not only as pediatricians or psychiatrists, but also as mediators, social workers and counselors.

It is clear that through the integration of school nurses and community based mental health and family services there would be a more efficient and effective use of the physicians' expertise and might result in better integration of the family into services in their community.

3.3.1.5 Advantages and Disadvantages to Offering Medical Services in Schools

There are a number of insights gained from having medical doctors conduct consultations in schools rather than in their office. Their mere presence in a school has had an impact on the school and community, signaling a more accessible and responsive health care system. For many parents, particularly in low socio-economic communities, the school space is familiar terrain for both parents and children, and is easier to access that an office space outside their community. Some of these parents have discomfort in dealing with people in positions of authority or expertise, and are afraid to ask questions. In a team consultation questions and answers can come from the teacher, parent or physician. At times physicians report that they serve as a mediator between parents and the school, attempting to bring clarity and understanding the needs of the child encountering difficulty.

Parents in higher socio-economic communities tend to already be more integrated into the health care system, have their own primary care physician, and often have the resources to access private services for mental health problems. They are less comfortable with having a consultation in a school setting; however, they are willing to participate in the initial consultation.

The C.O.P.E. team brings the coordination of early identification, consultation with the child, family and teachers, case planning, assessment and referral to the school site. This single site enhances the tracking of students and follow-up with parents. The team consultation provides physicians with ready access to information that would otherwise be very time consuming to collect if the consultation was done in the doctor's office. In a team consultation the physician is able to attain a more comprehensive understanding of the child in the home and school setting and to access the perspective of teacher and the parent.

3.3.1.6 Physicians as Part of Multidisciplinary Teams

Not all physicians are trained in, nor experienced at participating in and facilitating group consultations. They have to be able to facilitate the opportunity for all voices to be heard, to ensure the child is not left out, to deal with/anticipate the disclosure of confidential information, and to manage the flow of information. Physicians' interpersonal skills become critical in such a group dynamic. In a group situation with other professionals present, participants at times feel vulnerable because their judgment can be open to question, and their practice open to the scrutiny of others.

The professional style and personal disposition of the physician determine if they are better suited to working in a school that caters to families who are low-income, have low levels of education and are high risk; while other physicians are effective in dealing with the educated, high income, high risk families. We are learning that what makes a C.O.P.E. team effective is very dependent on the interplay between established physician practice patterns and how well they fit with team and family needs. Our quantitative research indicates that some teams appear to have more impact in their area than others. For example, CLC 6 reflects the most positive change in the cases seen through C.O.P.E. This is the one particular CLC where the physicians work as a team, have their private/clinical practice in the area, and are continually questioning and reflecting upon their effectiveness in working in the schools. It is this team that is most likely to provide treatment for the children through their already crowded private practice; and it is this team that is most anxious to receive feedback on their impact and success of their practice in schools. This team is interested in understanding how other teams more experienced in team consultations work in school settings. Further study is required to capture the different models and practices of physicians in each CLC, and to provide opportunity for them to engage in professional dialogue regarding their involvement in C.O.P.E.

3.3.1.7 Professional Development to Enhance Team Effectiveness

Having a team approach to the initial consultation with parents results in enhanced communication between the school and parent, the school and physician, and the physician and the parent. For example, the group consultation may result in parents understanding that the presenting problem does not reside in the school, or relationships with the teachers, but in the child or family. Similarly, teachers have the opportunity to gain a better understanding of such complex problems as ADD and ADHD, child neglect and abuse, and other related mental/social welfare issues. Through the group consultation process teachers become more knowledgeable regarding how to effectively present a problem to a physician (what information to make available to them). They become more skilled at identification of problems, and they have a better understanding of what to expect from the health care system, what services and agencies are available, and the names of people they can contact. Similarly, the family liaison also has the opportunity to gain an enhanced understanding of complex problems, identification of difficulties children present, strategies and resources to address these difficulties, and resources with the school system. The family liaisons share their expertise in case management, strategies and support mechanisms for families in duress, and conflict resolution.

Physicians also have an opportunity to understand the everyday life in schools and what they can expect from the school system. The cases presented in C.O.P.E. tend to be much more complex than those they would encounter in their clinical practice. In a clinical setting specialist tend to see children who have already been through a screening process, so the presenting problem is more clearly defined. The school setting creates a sense of urgency and immediacy to attend to the child's problem, shifting the consultation to one of problem solving rather than treatment in orientation.

The group consultation is a vehicle through which all participants have an opportunity to examine presenting problems from different perspectives and to increase their knowledge and understanding of these problems.

3.3.1.8 Linkages and Follow-up

At the school site it is critical to have established contact people who can implement school-based recommendations and provide the continuity within the school system so that the child does not get lost and there is reliable follow-up. For students who are transient and frequently move around the city, there needs to be across school linkages. These school system contact people serve as the "glue" that provides the link between C.O.P.E. and the classroom, school and services within and external to the school system. In the C.O.P.E. program this continuity and linkage is provided by CLC learning specialists. These people are "capacity builders" when they are committed to the program and have a good working relationship with the medical team; but they can be capacity inhibitors if they do not agree with the program or the recommendations.

Another person that is central to the success of the C.O.P.E. program is the Family Liaison. Currently there is only one Family Liaison for the whole C.O.P.E. project, but it is apparent from the intensity of work that there needs to be one Family Liaison for each CLC. The Family Liaison is involved in consultations with the family, school and doctor, takes notes of recommendations and referrals made in meetings, conducts home visits to gather additional information for medical records and to assess family functioning. S/he will submit a written report based on his or her assessment of the family situation. S/he will brief the consulting doctor on cases and reviews progress of cases. While the CLC Specialist is the key linkage in the school system, the Family Liaison is the key support for the family facilitating linkages to services that meet the family's needs. They also provide follow-up interviews with parents to ensure the family understands recommendations, and determines if they need assistance in implementing recommendations. For example, the Family Liaison may transport families to the Alberta Children's Hospital to have tests completed, may assist families to apply for subsidized housing, arrange for food hampers, attend meetings between the family and the school to clarify issues and provide support, and facilitate referrals for in-home support programs.

C.O.P.E. was originally conceived as a mechanism for the early identification of children at risk for psychiatric (social and emotional) disorders an/or developmental and learning difficulties with the intent identifying the best course of action to address their needs. C.O.P.E. was designed to provide a diagnosis rather than treatment. However, due to the complexity and urgency of presenting cases, the majority of physicians scheduled follow-up visits with families, and some physicians observed children in the classroom setting. In all cases physicians made recommendations to outline a "pathway of care" for the child and family. The Family Liaison reviewed these recommendations with the family. In the second year time was scheduled for the physician and family liaison to review cases together, and to then discuss them with the family and a school representative. Through this mechanism there is a shared responsibility for addressing the needs of the child. It became clear that communication and follow-up were critical to the success of C.O.P.E. in addressing the needs of children and their families.

3.3.1.9 Goodness of Fit with C.O.P.E. Model

C.O.P.E. was designed to function as both a research project and a medical intervention. Therefore, particular areas of the city were selected to represent families from different socio-economic levels, and schools representing a high concentration of coded children with mental, behavioural or learning disabilities, and schools with lower concentrations of such children. In addition, each C.O.P.E. medical team was unique, and how the program was realized in practice was dependent upon the idiosyncratic nature of the team members and how they conducted consultations, as well as the context in which they worked. C.O.P.E. physicians were challenged with determining how to make school-based consultations work within the existing capacity of community based services. As a consequence, the implementation of the C.O.P.E. program or intervention is highly contextualized and contingent upon the dynamics of those involved in each case, and the nature and complexity of each case.

Despite variance among the practices and dynamics of the C.O.P.E. team, the physicians and Family Liaison agreed that the kinds of cases addressed through C.O.P.E. fall into three categories:

1. Complex cases in which the child's pathology was amplified by a chaotic, disordered, and often impoverished family environment;
2. Cases of children with mild to moderate developmental, emotional, or behavioural difficulties; and
3. Cases in which the physician served to mediate differences between the school and the family regarding the child's presenting problem, and to create strategies to address the family and child's needs.

Appendix H contains three case vignettes to further illustrate some of the issues that emerged for physicians with respect to these types of cases.

Physicians felt overwhelmed cases presenting complex, social-emotional problems[2]. They would seldom see such cases in their private practices, and only when the problems are more pronounced would the children be seen at the Children's Hospital. They felt that a community-based multi-disciplinary treatment team was required to deal with the urgency and complexity of these cases. The most alarming and surprising dimension of these cases was the level of child poverty. Although C.O.P.E. is designed to diagnose and refer families to timely and appropriate medical services, the physicians felt that these cases were beyond the scope of C.O.P.E. In complex cases a "path-way of care" needs to be created in which C.O.P.E. can effectively be the point of identification; however, each case needs a Family Liaison to assist families in navigating their way through medical and social services, not to mention accessing food banks and subsidized housing.

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[2] Comparative data between the C.O.P.E. sample and children in the Canadian population indicate a very high degree of difference, with the children in the C.O.P.E. sample performing more poorly on all the mental health indicators except that measuring "prosocial" behavior.

Based on the three kinds of cases seen through C.O.P.E., and the effectiveness of C.O.P.E. in having a positive impact on the health of these children, it is clear that the key role that C.O.P.E. can play in creating a coordinated community-based system of care is to coordinate the in-take, diagnosis and referral of children identified through school based programs. The result would be a pyramid model of a system of care, in which C.O.P.E. would be at the top coordinating the early identification and referring children and their families to the various levels of services, with core services (food, shelter, protection) providing the foundation of the pyramid.

3.3.1.10 Education and Health Care Systems Working Together

One of the outcomes of C.O.P.E. is to create a system of care directed towards the early identification of children with emotional, behavioural, and learning problems. This child-centered/community based system of mental health care brings together health professionals, educators and parents into a common decisional framework for health care diagnosis. However, establishing sustained relationships between the education and health care bureaucracies runs counter to the bureaucratic structure that is currently in place to manage these two distinct systems. Both the health and education (K-12) systems are publicly funded and universally accessible, with constitutional jurisdiction over program delivery residing with the provincial, rather than federal government. C.O.P.E. explicitly attempts to cross boundaries between the educational and health bureaucracies, bringing personnel from both environments to be involved in the diagnosis of mental health problems that currently consumes approximately 50 percent of the special education budget in Alberta schools. C.O.P.E. was funded through the *Health Transition Fund*, a federal government response to the "National Forum on Health" to support innovations leading to a more integrated health care delivery system. To encourage continued awareness and support for C.O.P.E., a Steering Committee comprised of 17 representatives from the local and provincial mental health community and the local school system was created. These representatives convened twice a year to respond to updates form the C.O.P.E. research and administrative team regarding the challenges, obstacles and success of the C.O.P.E. program. At these meetings C.O.P.E. received critical feedback regarding how to better access services and how to better integrate services for children. This input is imperative in building a system of care for these children and their families. At the end of the two years of operation some funding for the continuation of C.O.P.E. has come from partnerships with some of the organizations represented on this committee.

3.3.2 Perspectives of C.O.P.E. Program Staff

The task of coordinating a program that involved the medical community, the public education system, a university research team, and parents had a number of challenges.

3.3.2.1 Finding Suitable Space in Schools

There are a number of factors that determine the kinds of space suitable for conducting on site collaborative team consultations. First and foremost is the need for privacy. In team consultations where sensitive information is often disclosed, there must be a space available for the physician to speak privately with a parent or the child, and to assess the child. The space must also be able to accommodate a team consultation. In a school setting available space that could be made available for C.O.P.E. was often less than ideal.

3.3.2.2 Creating a Data Base

C.O.P.E. was a program that continued to evolve as the team became more adept at conducting school-based consultations. Issues of confidentiality were always in the foreground, yet the system had to be user friendly and able to accommodate the request for and filing of new kinds of information. This necessitated a highly organized program coordinator and the use of a computerized database.

3.3.2.3 Scheduling Physicians.

One of the most challenging tasks in C.O.P.E. was the coordination of twelve physicians in five different locations, who devote a portion of their time to C.O.P.E. and still maintain their own private practice. Generally physicians committed half days on various days per month, and provided work schedules for C.O.P.E. that would span four-month periods at a time. Scheduling was confounded when parents did not attend meetings. This resulted in wasted time for the physician, who could not bill for services not rendered, and would result in having to find additional time to reschedule appointments in an already tight schedule. To coordinate attendance of all those involved (physicians, CLC Specialists, and teachers and/or administrators) weekly faxes were sent out by the C.O.P.E. coordinator informing all parties of the time and location for the meetings. The C.O.P.E. coordinator had to also ensure that all the files and appropriate information on each case would be available at each site visit. This resulted in the Family Liaison transporting files to each location, and contacting families to remind them of their appointments.

3.3.2.4 Communication

A constant challenge of coordinating the implementation of research and the C.O.P.E. program was to clarify the difference between what constituted research and what constituted the C.O.P.E. intervention. Parents and school-based personnel were interviewed for the research, and were often frustrated that this information was not used to inform those involved in the intervention. This problem was amplified in the Control Group where parents were interviewed, but their children never received direct benefit from C.O.P.E. In addition, parents expected C.O.P.E. to provide treatment, not just a diagnosis and referral to other medical services. This was evident in the six in-depth interviews with parents regarding their experiences with C.O.P.E. In five out of the six interviews parents felt that C.O.P.E. fell short because it did not provide treatment.

The material in Section 3 has presented a number of findings based on the independent assessment of the C.O.P.E. program implementation. Section 4 provides commentary both from the C.O.P.E. Coordinator and from the Family Liaison. Both of these commentaries provide additional insight into the logistics of implementing the C.O.P.E. program. Section 5 of this report returns to the lessons learned from this implementation of C.O.P.E. and provide a number of conclusions based on the analysis to date.

4.0 CHALLENGES, SUCCESSES AND BARRIERS IN ADMINISTRATION

4.1 Program Coordinator's Report[3]

4.1.1 Start-Up:

Set up of the C.O.P.E. program did not begin until mid October 1998. The Coordinator, Family Liaison and office administrator were hired. Activities in the first month consisted of the following:

- Locating a suitable location for the C.O.P.E. program staff to be housed
- Obtaining furniture, equipment for the office
- Designing forms for the program and getting approval of the forms from all parties. (CBE [Calgary Board of Education], Medical Ethics Board, FOIP [Freedom of Information and Privacy Act], Research) Examples of individual forms are included in C.O.P.E. Implementation Tool Kit (Appendix A).

Initially it was hoped that the program staff could be housed at a school site. Unfortunately, due to the cost associated with set up, it was prohibitive. Consequently, the C.O.P.E. office was set up in the CBE Student Service building. This was economically advantageous-shared phone system, photocopying, office space, care taking and also allowed for communication with key education system decision-makers.

4.1.2 Introduction of C.O.P.E. to the School System

The introduction of C.O.P.E. to the eight Collaborative Learning Communities (CLCs) began in November of 1998. Initially the coordinator and family liaison met with all of the specialists of the eight CLCs. It was decided that one specialist from each CLC would be the C.O.P.E. contact person to facilitate referrals and provide follow-up.

Individual meetings in the study group (CLC 1,5,6,8) were then set up. Principals met with the C.O.P.E. team (physicians, coordinator and family liaison) and the referral process was explained and a package was handed out. (See Tool Kit)

In the control group (CLCs 2, 3, 4, and 7) dissemination of the C.O.P.E. program varied. The coordinator and family liaison met with the specialists of the four CLCs and offered to meet with the principals from each of the control group schools in each CLC. A flow chart of the process for the control group was provided (See Tool Kit). Specialists from three of the CLCs chose to introduce the program themselves.

Intervention sites were then located in each of the study group CLCs. Based on the demographic lay out of CLC 5, two intervention sites were identified based on the premise the closer access to services the easier for families to utilize.

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[3] The C.O.P.E. Implementation Took Kit is included as Appendix A.

4.1.3 Medical Assessment in a School Environment

Each of these schools was equipped with an examination table in the nurse's room (eye chart, scales) and a medical bag. Each setting also had a resource box providing information on numerous services in the community. The boxes were also personalized with the resources that the physicians most readily used and were comfortable with. This was also a way to accumulate the appropriate medical forms that physicians require in each setting. (See Tool Kit).

Each intervention site was equipped with a toy box. Again, the toys provided varied, as physicians would request specific items that they preferred. All boxes consisted of the following:

- Coloring books, crayons, pencils, felts, paper
- Figurines of different types
- Lego, puzzles
- A ball

4.1.4 Challenges To Providing Services in the School

The space available in each school varied. A room that provided privacy was of utmost importance. It became apparent that privacy, ventilation, and sound played an important role. At times the physicians might want to speak privately with the parent which meant needing a second room. Also, in some schools, two doctors could be working on the same day. In setting up intervention sites it is important to consider all the variables, as this can influence comfort level.

Not all locations were ideal settings. Following are just a few of the difficulties that we experienced:

- When we met on the main floor of a two-story school building, we often had children walking and running around above us.
- Physicians sitting next to the public announcement system speakers nearly became deaf when announcements were blared over the system. (This could not be adjusted)
- Oil dripping from a light fixture onto one of our physician's notes. It should be noted that generally, the physicians had a sense of humor about these, and other situations.

It should be noted that generally, the physicians had a sense of humor about these, and other situations

4.1.5 Information Management Challenges

Additional instrumental tasks that were essential to the smooth running of the program included:

- Setting up the book-keeping for the budget
- Organizing the process for dictation

- Establishing dates and times that physicians were available to spend with C.O.P.E. Generally, physicians offered to work half days. They provided schedules for four-month periods at a time.
- Establishing the C.O.P.E. steering committee

Setting up a database took on a whole new meaning of the word *challenging*. Determining what information would be valuable to be included in the database over two years changed dramatically. Additions were continually being made to the working database, especially at the beginning of the program. At the same time, new referrals were being received and slowing down the process. This is a very important task, as over the course of the two years, different information was requested on numerous occasions. Developing a user-friendly system is highly recommended. This program found Excel a useful system. (Tool Kit lists the data that was documented)

Working files also required a great deal of refinement. The program attempted to accommodate all requests that the physicians made in setting up working files. (See Tool Kit for a template of a working file). These files have been kept in the C.O.P.E. office in a locked filing cabinet. C.O.P.E. program staff members brought the files to the physicians meetings at the school.

4.1.6 Organization and Scheduling Challenges

The scheduling of appointments for twelve physicians situated in five different locations required very detailed documentation. Again, the system incorporated needed to be user-friendly, as all members of the C.O.P.E. team needed to access this information. (Tool Kit illustrates how the schedule was set up on a Monthly Calendar). This allowed program staff to see at a glance what physicians were booked, and whom they were booked to see. (Tool Kit illustrates an example of a weekly record that tells us if the Community Physician form has been received). (In the Tool Kit is an example of a detailed schedule of one week's appointments.) A considerable amount of information is required. Several of the physicians worked in more than one location. For those physicians, the location of the appointment would also be documented.

To keep all parties updated on scheduling, faxes were sent out each week to remind them when their appointments for the next week were scheduled for. (These parties were: C.O.P.E. physicians, CLC specialists, and all schools involved with C.O.P.E.). (See Tool Kit for examples of these faxes).

4.1.7 Procedure and Process Challenges

Initially, to start up the program, blocks of half days were set up with each team of physicians. The C.O.P.E. specialist from each CLC organized which schools would present cases to the physician. This meeting was called an "Initial Consultation." The school would come to the table with the C.O.P.E. referral form and CBE consent forms completed. The C.O.P.E. team would review the information on the C.O.P.E. referral, and an informal discussion would take place. At this meeting, recommendations would be made. Depending on the case, physicians might recommend a strategy in the community or might request further information. In most cases, the physicians decided who should see the student and family – a pediatrician or psychiatrist, and in some cases, both. The appointments would be scheduled and it would be the school's responsibility to go back to the family with the date and time. Once start up was completed, periodic Initial Consultations were scheduled to intake new referrals throughout the course of the program.

There were two different processes, depending on whether it was a pre or post research involvement case. The pre-research cases had to have parents and child interviewed prior to the physicians meeting. The Community Physician Form (See Tool Kit) also needed to be completed by the child's doctor and returned to the program prior to the C.O.P.E. physician meeting. At the time the Research assistant met with the family, they would go over the C.O.P.E. consent form, have it signed, and explain the physician form. (See Tool Kit).

Post research, it was the schools' responsibility not only to introduce the C.O.P.E. program, but they also had the C.O.P.E. consent forms signed and explained the need for the physician form to be completed. Post research, new post research forms were developed (See Tool Kit). Post research, there were times when the Community Physician Form would be returned to the C.O.P.E. office before the Initial Consultation. This was an advantage, as sometimes the family physicians would provide information the school wouldn't have at an Initial Consultation.

As mentioned previously in this report, a list was kept of what physician's forms were received prior to a C.O.P.E. meeting (See Tool Kit). Once research had conducted their interview, C.O.P.E. program staff would follow-up those cases where the form hadn't been received. The C.O.P.E. physicians required this form prior to their meeting with the student.

The C.O.P.E. coordinator spent a large part of her time following up on these forms. Numerous calls to schools, parents, and physicians were needed to have these forms completed. As a result of the time factor, an administrative assistant was hired to assist the coordinator.

4.1.8 Medical Consultation Challenges

The physicians' consultations with the student and family were held in the designated C.O.P.E. school of that family's area. In attendance at this meeting were the C.O.P.E. physician, student, parent(s), a C.O.P.E. program staff member and a representative from the child's school (principal, assistant principal, resource teacher, teacher, etc.) Depending on the case, if there were other individuals involved, they could be invited as well. For example: school psychologist, child welfare, therapist in the community, CLC specialist, etc.

A block of two hours would be scheduled for the C.O.P.E. physician meeting. The C.O.P.E. program staff member took notes and summarized the recommendations that would be made at the end of the meeting. This person would also do whatever follow-up was required: contacting parents and school, assisting the family in scheduling a meeting in the community, and coordinating follow-up appointment(s) with the C.O.P.E. program if required.

After seeing a student and family, the C.O.P.E. physician would write a letter summarizing the concerns and recommendations that came out of the consultation. This letter was send to the community physician and the family. This letter is considered a medical document and as a result, the school could not receive a copy. This created difficulties with the schools, as recommendations were not always communicated clearly from the school representative at the meeting to others in the school.

As a result of the break down in communication, a form was developed where recommendations from the consultation could be documented and shared. The parents would read this at the meeting and sign, indicating approval. This form could then be given to everyone who attended the meeting. (See Tool Kit for the C.O.P.E. consultation form). This form was used in the last eight months of the program. It allowed everyone to leave the consultation with the same information, resulting in better communication and follow through.

4.1.9 Challenges in Follow-up

C.O.P.E. was originally designed to provide early medical consultation to elementary schools and families where children were identified with emotional, behavioural, or learning problems.

A consultation was initially thought to be a one-time meeting that would bring all relevant parties together (school, child, parent, physician). This allowed the physician to have access to the school and home issues impacting upon the child, and to pull all of the information together.

The physician would then make recommendations on how best the child's progress could be supported. In some cases, a diagnosis was made with a recommendation on how to manage the diagnosis.

What evolved as a result of the complexity of some cases was the need for some cases to be seen a second time or more. This was necessary to clarify diagnosis, better understand the complexity of the issues, or reassess how things were going in two or three months given the issues, and assess if the recommendations had to be modified.

Once the need for follow-up was identified, it took on several different forms. The following are some of the approaches taken for follow-up in the order they occurred over the last two years:

- Initially, schools, physicians, family liaison and families would request a follow-up meeting.

- If the physician initiated a medication trial, this invariably resulted in a follow-up appointment.

- C.O.P.E. coordinator and family liaison reviewed all files, and those cases presenting some difficulty would then be reviewed by the physician.

- When families were a no-show at an appointment, the school representative, physician and C.O.P.E. program staff would review all cases referred by that school.
- In the second year of the program, time was set up with each physician to review every case they were involved in.

In the future, the C.O.P.E. program may want to set up a more formalized follow-up process. The following are points to consider:

- Obtain input from the physicians regarding a follow-up process
- At the beginning of the year, schedule in regular time with each physician to review cases.
- Have the school representative present for these reviews
- Communicate the follow-up process that is incorporated to all relevant parties.

4.1.10 Project Coordinator's Recommendations

Throughout this two-year project, there were numerous obstacles to overcome and work through. Fortunately communication and persistence resolved most of the key challenges. The following summarizes some of those challenges, including some recommendations for overcoming them:

1. Budget information needing to be disseminated in three different formats; One for the University of Calgary Trust Accounting, a second one for the Alberta Primary Health Care Project, and the third, a detailed account of all funds for internal purposes. A background in accounting would have been a valuable asset as the coordinator spent a great deal of time on budget management.

2. Communicating with all parties involved with C.O.P.E. Information such as research process, changes in forms, updates were communicated through several forms, faxes, letters, and phone calls. What appeared to be most effective was face to face contact, however this was also the most time consuming.

3. There was also a continual need to clarify the C.O.P.E. program's mandate. This, most often, came from schools requesting treatment for their students. C.O.P.E. provided consultations to schools, not treatment. The physicians also expressed concerns regarding the shortage of treatment resources.

4. Explaining the difference between the C.O.P.E. research and the actual C.O.P.E. intervention program was a constant challenge. Schools and parents often saw the person (research assistant) that interviewed the family as part of the intervention team. There was also confusion regarding the control group. Individuals in the school system, as well as in the community, had difficulties understanding that

control group participants that were interviewed by research, did not receive C.O.P.E. intervention.

5. One of the irritants for the program and physician were those scheduled appointments that families did not show up for. Efforts were made to call families to remind them of their C.O.P.E. appointment, however, there continued to be some no shows. Mondays in particular were bad days. Perhaps a back up plan could be developed in order to use the physicians' time when this situation arises.

6. There were times when families and/or schools would call regarding a crisis. It would be useful to incorporate a process for managing these situations with the physician who had consulted on the case.

7. The involvement of CLC specialists made a significant contribution to the flow and smoother functioning of the program. The program ran more efficiently and effectively when the specialist had an active role in setting up the cases to be screened at the initial consultation, and attended the consultation(s) with the physician(s), school and family. The specialist in the consult was able to identify strategies and or programs that could also support the child/family.

8. There was not a week that went by where issues did not have to be resolved, related to the implementation of research. The relationship between the research team and the C.O.P.E. administrative team needs to work cohesively in order to have both parts of the program work effectively.

9. The type of client that C.O.P.E. was expected to serve was anticipated to be somewhat transient. Approximately one third of C.O.P.E. referrals moved. These moves required a significant amount of time tracking the student and clarifying C.O.P.E.'s mandate to the receiving school.

10. The advancement of students from one grade to the next also required C.O.P.E. program staff to spend time introducing C.O.P.E. to new schools, teachers, and administrators. For this reason, it would be more efficient to start and end the research component of the C.O.P.E. program in a school calendar year.

11. There were some schools that the C.O.P.E. program was offered to, that chose not to participate in the project. They felt that C.O.P.E. would add to an already high workload, and they questioned if C.O.P.E. would be of benefit to them or the student.

12. The climate of the CBE system also affected the C.O.P.E. program. In the spring of 1999 there was a possibility of a teacher's strike. This had a direct effect on referrals to C.O.P.E. during this time.

13. At the start up of C.O.P.E. there were a number of schools that misunderstood the process and function of C.O.P.E. The C.O.P.E. coordinator and specialist spent time clarifying and resolving conflict related to the program with each of these schools.

14. Start up in October versus September:

There are numerous adjustments and pressure at the beginning of a new school year for administrators, teachers and students. At this time, there is pressure on all schools to identify students who need coding. September is a good time for the C.O.P.E. program to do any follow-up from the previous year. Once schools have completed coding, they are better able to identify children that could benefit from a C.O.P.E. referral.

Effective communication is one of the most significant parts of implementing a program like C.O.P.E. to a huge system like the CBE. Numerous issues arose as a result of miscommunication. For example, C.O.P.E. physicians might recommend an educational assessment, as this might be of value in identifying a child's needs. In turn, the school would go to their appointed psychologist and say, "The C.O.P.E. physician says you have to assess this child." This miscommunication occurred several times and the coordinator needed to clarify to both the school and the psychologist that C.O.P.E. physicians make recommendation and it is up to the schools to determine what students they prioritize for testing.

The success of establishing a program such as C.O.P.E. requires a dedicated group of program staff members. As the coordinator, there were multiple levels of tasks to perform each day. The smooth functioning of the intervention team being the most important task. This position requires a broad range of skills; accounting, knowledge of "systems" and how to work cohesively within them, scheduling a large number of individuals, and skills in conflict resolution – to mention just a few. The multi level of challenges also provided a never-ending wealth of knowledge and experiences. The success of the program was felt through the feedback that was received by parents, CBE staff and individuals in the community. Participating in such a cutting age project has been a privilege!

4.2 Family Liaison's Report

4.2.1 Establishing a Clear Job Description

The biggest challenge was defining a job description for an extended Family Liaison role in C.O.P.E. The following Family Liaison story illustrates the challenges and experiences in the role.

Family Liaison Story

The Family Liaison plays a critical role in the strength of the C.O.P.E. process. He ties the pieces together to allow for greater movement along the path to progress in the lives of the families and children seen through C.O.P.E.

The physicians have incredible knowledge and expertise in weaving through the numerous symptoms of a case to identify the heart of the issue(s) and then make sound, achievable recommendations to the family, school and primary health care provider. However, the ability to follow a case from the beginning is very beneficial. Thus being able to be involved from the initial consultation where the school presents the cases to the C.O.P.E. team enables you to get a snap shot of the issues involved, (at least from one perspective). Then when the Family Liaison is involved in the consultation with the family and physician, he is able to get a more complete picture of the situation and the dynamics involved. As more information is added to the picture, there is a base to verify and clarify information.

When the program first started a C.O.P.E. program staff member would take notes of the issues of the consultation and record the recommendations for the C.O.P.E. files. However, when I (the Family Liaison) would have to call a family to follow up on an issue from a consultation I found that the family was not sure what the recommendations made at the consultation was. So I started making a follow up phone call to all the families where I was involved in the consultation a week after the consultation. I would call to clarify the recommendations from the consultation and to provide support in achieving/following through on the recommendations. We soon found that the school was also not sure what was achieved or gotten out of the consultation with the physician. Thus a C.O.P.E. recommendation form was developed and it has been extremely beneficial. Both the school representative and the family go away with a list of written recommendations from the consultation. So now when I follow up with a family, they have a copy of the list of recommendations made at the consultation.

In the future I feel it would also be very helpful to state at that time of the consultation that the parent and school will be contacted one week after the consultation. Then three weeks later to follow-up to see if there are any difficulties or obstacles following through on the recommendations.

The role of the Family Liaison is to help facilitate linkages to services that will meet the families needs. As the Family Liaison I have transported families to the Alberta Children's Hospital to have tests completed. I have gone with them to apply for subsidized housing. I have arranged for food hampers. I have attended meetings with the parents and the school to clarify issues and lend support. I have helped facilitate referrals to in-home family support programs. I have arranged for families to have a review consultation or for a family to see another specialty on the C.O.P.E. team.

At the review consultation I brief the consulting physician on the case, what has happened, issues at this time and what questions are being asked. Again I will follow up with families after the consultation to review recommendations and facilitate follow through on the recommendations that came out of the consultation. I feel it would also be beneficial for the Family Liaison to follow up with the school and specialists to monitor the progress of the student over time. At times there is slippage, where things fall off track and identifying this at an earlier stage rather than a later stage would be more beneficial. Keeping good contact notes is also a helpful tool for reviewing the history and progress of the case. Reviewing the progress of the cases at various intervals with the physicians to determine if the situation is progressing well or if other recommendations to help the progress of the case can be determined would also be beneficial. Physicians like to know what has happened to a family they consulted on.

4.2.2 Additional Challenges Experienced in the Family Liaison Role

The following items are critical to success in my role and to the overall success of the C.O.P.E. program.

- Having a clear criteria regarding C.O.P.E. cases
- A consistent school contact that can help to identify and facilitate referrals
- Need to establish a clear process for intake and follow-up (i.e. Using a Flow chart)
- Need to have a team member (Family Liaison) facilitating and following up on recommendations from the consultation with both the school and the home.
- Need to set up a review date or follow-up date with the consulting physician to see how the situation has developed.
- Multiple sites if possible, the closer the family has to go to see a physician the better the chance of a follow through with initial appointments and follow-ups.
- Money to allow teacher to attend consultations (by paying for substitute teachers)
- Ensuring that the parent and teacher are together at a consultation allows for a better assessment and clearer diagnosis.

Given the volume of work, there needs to be no more than one Family Liaison per physician team. It is very difficult now to keep up with the changes in resources in an area, much less, citywide. Thus being located in 1 or 2 specific areas would aid the C.O.P.E. Family Liaison in being more familiar with the resources in that area that can better meet the needs of a family.

The Family Liaison is a case manager. After attending 3 days of consultations it takes 2 full days just to do follow-ups and then you are into the next week. It will therefore be important not to confuse Family Support with Family Liaison. Time is not available to do intensive work with a family.

The physicians are providing very good assessments and identifying issues that need to be addressed, but then there is no where to send these families for the help they need. Thus, C.O.P.E. having more formal linkages to other resources would be very beneficial. For example, COMPASS, Families First, both of these services provide in-home family support to families to strengthen parenting skills and improve a families connection to community resources. U OF C Family Therapy program – to deal with family dynamic issues and marital issues, etc. If the Family Liaison has these linkages, then all he would have to do is make the necessary phone calls or fill out the necessary forms to allow for a smooth transition to link the family up to other services and resources the family needs.

4.2.3 Response to Challenges Experienced

There needs to be support from the specialists attached to the schools in that CLC. There needs to be a logical problem solving progression when dealing with students who display learning, behavioural or socio-emotional difficulties. For example the school identifies a student with the above difficulties. Concerns are discussed in a school resource group meeting (SRG). Then school initialed support – for example from the Resource teacher, student's name put forth for psycho-educational testing, etc. If the regular school program is not meeting the students needs, then a discussion with the specialist to determine what other system supports are available to the student/school to meet the student's needs should take place.

It is at this point that the specialist/school might suggest C.O.P.E. to determine what medical factors are impacting the student's progress. This process would be preferred rather than the school identifying a student with difficulties and then bringing it to the C.O.P.E. table without specialist or the school psychologist involvement.

A part of the reason we are seeing these short cuts is because the schools are stressed – teachers and administrators. Resources are scarce and the needs of the student(s) are sometimes great. There are very talented teachers who are able to manage incredible difficult students that exhibit multi-level needs/difficulties. There are also very creative and flexible administrators who try to accommodate the needs of these students. This is where there needs to be specialist involvement that can acknowledge the need, and help the school access alternative placements that better meet the needs of the student. This in turn would reduce the stress of the teacher(s) and administrators. However, if the school goes from 'problem' with student to C.O.P.E. they will miss other interventions along the way. This has been demonstrated several times in consultations with the physicians where the school presents the concerns and the specialist being in attendance has identified several interventions that could have been tried or accessed prior to the medical consultation.

4.2.4 Family Liaision's Recommendations

1. The recommendation form used at the consultation has been very useful and effective. The school representative and the family go away with a list of written recommendations from the consultation. Before this form was implemented neither the school nor the family was sure what was achieved by having a consultation with a physician. (See Tool Kit)

2. The consultation letter being a part of the intervention. The parent gets a written report outlining the concerns and recommendation of what need to be done in order for their child to progress. The letter makes it more formal and official.

3. The follow up phone call after the consultation, to the family by the C.O.P.E. program staff that attended the consultation with the family is also very important to clarify the recommendations from the consultation and to provide support in achieving the recommendations.

4. Given the volume of work, there needs to be no more than one Family Liaison per physician team (CLC); 2 CLCs at the most. It is very difficult now to keep up with the changes in resources in an area especially citywide. Thus being located in 1 or 2 specific areas would aid the C.O.P.E. Family Liaison in being more familiar with the resources in that area that can best meet the needs of family he sees.

5. A physician follow-up in almost every case to help with the perception of the completeness of care, to affirm progress and direction.

6. Schools are asking specific learning strategies/intervention possibly need a psychologist to consultation on these issues.

7. Consider the Family Liaison is a case manager. After attending 3 days of consultations it takes 2 full days just to do follow-ups and then you are into the next week. It will therefore be important not to confuse Family Support with Family Liaison. There is no time available to do intensive work with a family.

8. C.O.P.E. having linkages to other resources would aid with providing more support to families and schools. It would aid in helping getting families hooked up with resources. The physicians are feeling they are doing good assessments and identifying issues, but then there is no where to send these families for the help they need.

5.0 SUMMARY AND CONCLUSION

5.1 Lessons Learned

The C.O.P.E pilot program involved the implementation of a process designed to better integrate a group of mental health professionals – child psychiatrists and pediatricians – within the public education system for the early identification and more effective treatment of children with emotional, behavioural and learning problems. A key expectation of this program is that through better integration of these mental health and education providers in a school-based mental health care setting, which also involves the participation of the child and his or her parent(s), an earlier and more complete diagnosis of the child's social, emotional and/or learning problems will ensue. It is also the expectation that an earlier and more effective diagnosis will lead to more effective treatment. However, the C.O.P.E program itself did not in the pilot phase bring any additional resources to bear on the provision of a more effective treatment.

An assessment of the C.O.P.E program to date reveals a number of significant lessons learned from this project, that can be categorized as outcomes and context:

5.1.1 Outcomes

- Improved student performance on psychosocial indicators: Parent responses to questions about the change perceived in their child four months and eight months after in-take into the C.O.P.E program reveal significant improvements with performance and high levels of satisfaction with the program. Follow-up interviews with parents indicate particularly positive impacts among children of parents with lower socio-economic status, suggesting a heightened level of efficacy for a school-based mental health system for such families.

- Improved parent understanding of indicators of social, emotional and/or learning problems: Parents of children in the C.O.P.E program revealed a higher correspondence between general perceptions of either improved or deteriorating conditions, and perceptions of change on specific indicators of mental health. Involvement in the C.O.P.E program appears to provide parents with a greater capacity to identify the characteristics of various mental health attributes – such as hyperactivity, inattention, conduct disorder, and others. This increased capacity among parents is a significant first step towards improved outcomes for children.

- Improved physician understanding of the complexities with which children are presenting social, emotional and learning difficulties: The integration of the physician team of mental health professionals with the school system provided significant new opportunities for learning among the medical personnel. The school-based consultation, in which physicians were brought together with the child, parent(s), teacher, and other school resources such as the vice-principal, CLC specialist(s) and others, provided the medical team with a much richer information base from which to provide a diagnosis of the child's problems. The manner in which the child presents his or her problems was more fully identified and contextualized.

This improved information better enabled the physicians to provide an earlier and more complete diagnosis of the child's problems.

- The school-based consultation had a similar effect on the teachers and other educators at the school: By involving teachers, principals or vice-principals, and CLC specialists in the consultation, the expectation is that educators are provided with improved capacity in identifying social, emotional and learning problems, and that they also are provided with strategies to respond to specific problems. The results from the C.O.P.E pilot program are suggestive that such improved capacity has developed among many of the teachers involved with the C.O.P.E program. For example, although detailed quantitative analysis of this process is not possible with the survey data collective, observational qualitative data revealed improvements over time in the manner in which teachers presented cases to the C.O.P.E medical team. Consultations later in the life of the program tended to be more focused in the information presented, and had a higher level of precision. Furthermore, it should be noted that this is independent of the medical team providing in-depth professional outreach outside of the consultation sessions. Had such sessions been offered, it is expected that even higher levels of capacity building would develop.

5.1.2 Context

- Very high level of need among the student population: Many of the physicians involved in the C.O.P.E program expressed surprise and dismay at the very high level of need experienced by children within the public school system. A recurring theme among the physicians was that many of the cases presented were complex, with multiple mental health problems and often within a family environment in which a number of the parents themselves appeared to present mental health problems. Comparative data between the C.O.P.E sample and children in the Canadian population indicated a very high degree of difference, with the children in the C.O.P.E sample performing more poorly on all of the mental health indicators except that measuring 'prosocial' behavior. Subsequent analysis will examine more fully the assessment of teachers on the level of need among the student population, and their perceptions of the capacity of the schools presently to deal effectively with this need. Preliminary analysis suggests that many teachers perceive the need to provide improved mental health services within the schools.

- Presently underdeveloped linkages between schools and mental health physicians: One of the tasks at the outset of the C.O.P.E program involved contacting schools to arrange for the offering of school-based mental health consultations. Likewise, it was necessary to work with pediatricians and child psychiatrists to bring them into the school setting. An early observation was that this program involved the development of a new set of linkages among these groups, and that the amount of direct involvement between the educational and mental health systems was modest. Over time, it became apparent both to the physicians and to educators that a better integration of mental health services within the schools was advantageous to all involved in this project. Schools appeared to benefit from improved capacity, both directly through the physicians and also by improved learning by teachers and others in the schools. Physicians benefited through the provision of a much richer array of information available to them at the time of diagnosis. Parents benefited by a relative ease of access to the system, by improved learning and capacity-building personally, and of course through the improved social, emotional and learning outcomes for their children. In turn, the children benefited through improved social, emotional and learning outcomes.

- Fragmented mental health system for children is very difficult to navigate, especially for parents with lower social functioning: Beyond the C.O.P.E consultation, the study revealed a striking level of fragmentation in the mental health system, and many parents simply were unable to navigate this complex web to identify appropriate resources for their child. One of the outcomes of involvement in the C.O.P.E program for parents is improved navigational skills by better understanding the mental health system. A key element in this is the provision, through the C.O.P.E program, of a resource person to ensure appropriate follow-through on the recommendations of the C.O.P.E medical team. Parents in the C.O.P.E program are more likely than other Calgarians not to have a primary care physician, and thus lack one of the most obvious points of contact for the medical system generally and the mental health system more specifically.

- Billing at present is a disincentive to the C.O.P.E integrative process: Current billing policies for physicians do not encourage the kind of integrative, team-based, and preventive practices upon which a full integration of the C.O.P.E program is based. Some physicians are not able to bill for consultations with other health care professionals when the child is not present at the consultation, despite the need for such consultation in many of the complex cases presenting at C.O.P.E. In addition, public education and outreach functions, in which the medical staff provides either teacher education presentations or workshops, or parent education presentations or workshops, are not items for which the medical staff may receive remuneration from Alberta Health. This limitation acts as a disincentive for the establishment of such programs or practices.

- The C.O.P.E. model is generic and has promise for application in diverse settings. C.O.P.E has one natural replication site in a rural setting – Strathmore – supported through Student Health Initiative dollars.

- The C.O.P.E model appears to be effective in creating partnerships around children. The program is currently being considered for integration into the broader Student Health Initiative in Calgary.

5.2 Next Steps

The pilot implementation of the C.O.P.E program achieved many of the objectives identified at the time the project was approved. Most importantly, it resulted in improved diagnosis of children with mental health problems, and was a significant step toward better integration of the health care and education systems. The assessment of this pilot program will continue over the following months, with a wealth of data from parent and child surveys, teacher, principal and CLC specialist surveys, and the analysis of qualitative data for the case studies and interviews and observations.

A program of augmentation of the initial C.O.P.E pilot program has been proposed, and funding is currently being sought for its implementation. The augmentation would include the following elements:

1. Family physicians as part of the school-based team: Many children and parents in the C.O.P.E program have unmet health needs and do not have a primary health provider. The family physician on the team could deal with these concerns and either provide or facilitate access to primary health care. Many parents in the C.O.P.E program have unmet mental health needs. The family physician could provide primary treatment and where appropriate, referral. The family physician on the team, through participation in the collaborative consultations with pediatricians and child psychiatrists and education specialists, will build independent capacity to identify and treat a broader group of children who may present outside the school system.

2. Coordinated intake system to improve access to the appropriate level of care: The most effective initial consultations in C.O.P.E have involved all the player that might be involved in diagnosis or treatment activities beyond the C.O.P.E team, such as Alberta Mental Health or Alberta Children's Hospital. Linkages and follow-up plans can be made at the time of the initial consultation – improving both patient satisfaction and most probably compliance.

3. Parent empowerment and capacity building through provision of Family Liaison activities: Families who have difficulties gaining access to the system of services for mental health care experience difficulties in following through on recommendations made at the consultation. This reduces the efficacy of the initial intervention and does not promote optimal outcomes. The Family Liaison helps the family understand and follow-through on the recommendations made. The C.O.P.E augmentation would involve improved Family Liaison resources and activities to promote improved capacity building among families in the C.O.P.E program.

4. Professional education to increase capacity to recognize and respond to mental health needs: Teachers who were involved in the process of identification and case planning as part of C.O.P.E seem to be more effective at carrying out recommendation and also had improved identification strategies with other children brought forward to C.O.P.E. The augmentation would result in increased professional education of educators, by the C.O.P.E medical staff, to increase school-based capacity.

5. Funding for joint intervention and other collaborative activities: The current fee for service model did not allow of a pediatrician and psychiatrist to work together to provide joint intervention, while receiving remuneration for the service. This limited opportunities for cross-consultation and mutual education that could have led to improvements in patient care and further refinements of the group consultation

model. The C.O.P.E augmentation proposes a change to the fee structure to accommodate the team-based, preventative approach on which C.O.P.E is based.

6. Improved knowledge of psycho-social outcomes through longer-term follow-up: The assessment of the C.O.P.E program to date is based on a relatively short-term intervention, ranging from 4 to 8 months. The augmentation of the program would extend the analysis for the cases involved in the C.O.P.E program to date, assessing the impact of the program over a longer time period, and thereby providing an assessment with increased validity.

5.3 Conclusions

C.O.P.E. is the beginning platform for the development of a comprehensive system of care for school based mental health services. It challenges those providing mental health services to reach beyond the patient-provider relationship to engage a fuller complement of professionals, parents, and caregivers. It provides a particular challenge to reach beyond the bureaucratic silos through which much of our educational and health care policies are developed, funded and implemented.

The C.O.P.E program has begun to develop a comprehensive system of care on the diagnostic end of the primary health care spectrum. By focusing on the diagnostic end of the continuum, the C.O.P.E program has demonstrated that implementation of a school based system of care has merit in improving psychosocial outcomes of children with mental health disorders. The intervention is generic and entails bringing additional information and resources into the decision point of identification of mental health problems by integrating physician services into the school system to work with children that the schools have identified as having potential social, emotional or learning problems. As a result, information brought to the decision point for physicians is more comprehensive, complex and contextualized by those who work and interact with the children on a daily basis. The analysis of behavioural and attitudinal data from the study reveals the significant impact this manner of diagnosis has on the children so identified.

It is a much more complex task to provide a comprehensive system of care directed at following up on the diagnosis provided by the C.O.P.E team. The C.O.P.E project made first steps into this area by ensuring the dissemination of information regarding services and facilities available for follow-up treatment purposes. However, its capacity to effect the provision of services is highly constrained by the absence of additional funding for a more comprehensive system of care aimed at mental health service delivery. The research findings of the present study may contribute to an assessment of the effectiveness of spending health care funding in redesigning a more comprehensive service-based system of care that is both school based and family focused.

An additional contribution of the present project is the provision of an assessment of the social and health policy dimensions of implementing a diagnostic-based system of care. The experience of the C.O.P.E program has revealed a number of barriers that impinge upon the implementation of a comprehensive system of care. Those barriers exist between sectors, between medical and educational professionals, and even between different medical professionals. The findings revealed that these barriers often could be permeated, and in some cases removed altogether. However, the findings also caution that the removal of barriers should not be taken for granted, and that their effective removal is neither a natural nor inevitable part of the challenge of implementing more comprehensive systems of care. Rather, it requires patience, perseverance, time and resources, and above all inspired and visionary leadership.

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APPENDICES

Community Outreach in Pediatrics/Psychiatry and Education Program

C.O.P.E.

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Keith Archer, PhD

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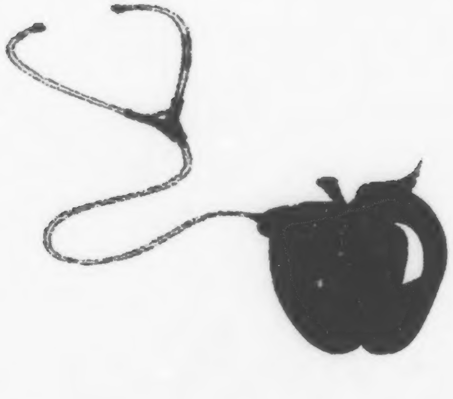

FINAL REPORT ON THE IMPLEMENTATION OF COMMUNITY OUTREACH IN PEDIATRICS/PSYCHIATRY AND EDUCATION PROGRAM IN CALGARY OCTOBER 1998 TO JUNE 2000

Prepared for:

Alberta Health and Wellness

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Community Outreach in Pediatrics/Psychiatry and Education Program

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June 2000

Appendix A C.O.P.E. Tool Kit

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C.O.P.E.

Tool Kit

C.O.P.E. Forms

C.O.P.E.
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School-Based Medical Intervention

A shared concern amongst parents, educators and doctors is early identification and intervention for children experiencing difficulties with their learning or behavior in the classroom setting.

The COPE Program is designed to serve families whose elementary school-aged children are experiencing difficulties with their learning or behavior in the classroom setting.

COPE is a collaboration between the Calgary Regional Health Authority, the Calgary Board of Education and the Departments of Pediatrics at the University of Calgary. Together, they have a joint commitment to work with families to better understand these problems and develop workable solutions.

To get information about whether the COPE Program is effective, the Division of Developmental Pediatrics is conducting a survey of elementary school students in certain areas of Calgary who are identified by the school as having behavioral/emotional difficulties.

The Purpose of the Study:

To determine if school-based medical consultation is an effective and efficient mode of service delivery.

Parents, teachers and doctors want to find out about and help change the behavior of children who have learning problems at school. This is a study of how to make this work better in Calgary schools.

Schools have been assigned to "Study Groups" and "Control Groups". The main difference between these two groups is that the study group includes medical doctors in school-based discussions of students with behavioral or learning difficulties.

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Researchers Participating In the Program:
Dr. Keith Archer
Dr. Lynn Bosetti
Elaine Foulkes

Participation in this study involves students and their parents filling out several questionnaires. Some participants will also be meeting with staff in the COPE Program for consultation regarding the student's medical, learning, or social and emotional needs. Teachers and educational Specialists will also be involved in the consultation.

We expect that by finding out about the needs of children having learning or behavioral problems in the classroom, and providing help at an earlier stage will result in improved learning and better coping skills.

Participant's responses will remain strictly confidential.

At the conclusion of the study, a summary of the findings will be made available tc the participants in the study.

Health Canada and Alberta Health fund the research Project.

SE-030 (91/12)

Calgary Board of Education

Parental Authorization

Direction: *Authorization is a signed statement of informed consent to provide special assistance for the benefit of the student. Signature must be provided by the parent/guardian if the student has not reached the age of majority. If the student is eighteen years of age or older, the student must provide consent instead of parent/guardian.*

Student Identification Information

Student's Name *(Last)* *(First)* *(Initial)*

Date of Birth ☐ ☐ ☐ Yr Mo Da

School Teacher Grade/Class

Consent (Indicate type ☐ of authorization.)

☐ I hereby consent to the provision of psychological assessment by and consultation with authorized staff employed by the Calgary Board of Education in regards to the exceptional needs of the aforenamed student.

I also acknowledge that I have been informed of the nature and intent of this assessment and I understand that school staff will subsequently review the results of this assessment with me and explain any forthcoming recommendations. It is understood that the psychologist will make the initial interpretation.

. . . .

☒ I hereby consent to the release to the Calgary Board of Education, and to any duly authorized agent hereof, all the records, reports of examinations, and information of medication, psychiatric/psychological, and/or educational assessments or program rendered to the aforenamed student.

Community Outreach in Pediatrics/Psychiatry and Education (COPE)

☒ I hereby authorize the Calgary Board of Education, and any duly authorized agent thereof, to release to:

Community Outreach in Pediatrics/Psychiatry and Education (COPE)
Name of school, district, agency, person, etc.

all school records, report assessments, and information of medical, psychiatric, psychological, and/or educational assessments or program rendered to the aforenamed student.

. . . .

Authorization Signatures

This consent and authorization will be in effect for the current school year.

Name of Consenting Person	Name and Role of School Official
Signature of Consenting Person	Signature of School Official
Date	Date

. . . .

Please Return To:

Role of School Official Telephone Number ☐ ☐ ☐ Yr Mo Da

Address

C.O.P.E.
Community Outreach in Pediatrics / Psychiatry and Education Program
c/o Calgary Board of Education,
Parkdale Centre 728 – 32 Street N.W.
Calgary, AB, Canada
T2N 2V9

COPE Consent Form (For Parents/Guardians)

Research Project Title: COPE, Community Outreach in Pediatrics and Psychiatry in Education

Investigators:	Margaret E. Clarke, MD FRCPC COPE, Program Director	Keith Archer, PhD COPE, Research Director

Sponsor: Alberta Health

Student Identification Information

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Student's Name (Last) (First) (Initial)

Date of birth

___/___/___
Yr Mo Day

School Teacher Grade/Class

Parents, teachers and doctors want to find out about and help change the behaviour of children who have learning problems at school. This is a study of how to make this work better in Calgary schools.

Schools have been assigned to 'study groups' and 'control groups'. The main difference is that the study group includes medical doctors in school-based discussions of students. Your child, whose name appears on the top of this consent form, has been chosen for this project. You have already been contacted about the need for further help for your child. Your child will be discussed within the School Resources Group (SRG) team. The SRG will include a pediatrician or a child psychiatrist if you are in the study group. Your child will be asked to fill in several questionnaires about the way they think and feel. Also, you will be asked to complete several questionnaires about your child and about family and school situations.

There are minimal risks associated with your participation in this study, and perhaps considerable benefits.

Participation involves your child meeting with staff in the COPE program for consultation regarding your child's medical, learning, or social and emotional needs, and/or with teachers and program specialists for similar consultation at a school in your area. If you join the program in Nov 1998 to Feb. 1999 you will be asked to fill out one questionnaire which takes about 60 minutes to complete, and two more questionnaires, 4 months and 8 months later, that take about 30 minutes to complete. If you start the program between March 1999 and June 1999 you will be asked to fill out one questionnaire at the beginning, and one more questionnaire 4 months later.

We expect that by finding out about the needs of children having learning or behavior problems in the classroom, and doing something to help them, will result in improved learning, and better coping skills.

The information gathered in this study will be used by the research team of the COPE project. All of the information will be stored in a secure place, and there will be no identifying information on these files. Your identity, and your child's identity, will remain confidential.

The findings of this study will not be released until the study is completed. At that time a summary of what we've learned will be given to those people who participated in the study.

This study will not require any financial costs to you or your family.

If you or your child suffer any injury as a result of being in this study, no financial compensation will be provided to you by Alberta Health, the University of Calgary, the Calgary Regional Health Authority, the Calgary Board of Education, the research and program staff. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

28-Jan-99

C.O.P.E.

Community Outreach in Pediatrics / Psychiatry and Education Program

Your involvement in this study is very important and valued. We cannot pay you to participate in this study. However, we can reimburse you, up to $15.00 per interview, for any costs that you have, such as bus fare or babysitting costs, to participate in the study.

To show that you have read the information above, and that you agree to be involved in the project, please check each of the boxes below that apply, and sign the consent form.

☐ I request that my child (named above) be referred to the COPE program for pediatric or child psychiatry consultation.

☐ I acknowledge that I have been informed of the nature and intent of this assessment and I understand that school and/or medical staff involved with this program will review the results of this assessment with me and explain any recommendations.

☐ I understand that I will be fully informed of the findings and recommendations.

☐ I provide consent for my child's doctor to disclose the information requested on page 4 of this form to the medical and research staff involved with this program.

☐ I provide consent for the Calgary Board of Education, and any duly authorized agent thereof, to release to the COPE program all school records, report assessments, and information of medical, psychiatric, psychological and/or educational assessments or program rendered to my child.

☐ I have read the information above. I understand the nature of the research, and I understand that as a participant in this study, my child will complete two or three interviews. I understand my child may withdraw from the study at any time, and this withdrawal will have no impact on his/her participation in this program. I consent to my child's participation in this study under these terms and conditions.

☐ I have read the information above. I understand the nature of the research, and I understand that as a participant in this study, I will complete two or three interviews. I understand that I may withdraw from the study at any time, and this withdrawal will have no impact on my child's participation in this program. I consent to participate in this study under these terms and conditions.

Your signature on this form indicates that you have understood to your satisfaction that information regarding participation in this research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Vandora Moxam, Program Coordinator, at 777-7240, ext. 2251
If you have questions about your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

Authorization signatures

Name of consenting Person	Name of Witness	Name of Research Staff Member
Signature of Consenting Person	Signature of Witness	Signature of Research Staff Member
Date	Date	Date

A copy of this consent form has been given to you to keep for your records and reference.

The investigator will, as appropriate, explain to your child the research and his or her involvement, and will seek his or her ongoing cooperation throughout the project.

The personal information contained on this form is collected in accordance with provisions as stipulated within the School Act and under the authority of Section 32© of Alberta's Freedom of Information and Protection of Privacy Act for the COPE Research project. If you have any questions about this consent for, please contact Vandora Moxam, Program Coordinator, COPE, Calgary Board of Education, Parkdale Centre, 728 – 32 St. N.W. T2N 2V9, 777-7240 ext 2251.

C.O.P.E.

Community Outreach in Pediatrics/Psychiatry and Education

COPE REFERRAL FORM

Student Name : ____________________ **School** : ____________________

D.O.B. : ____________________ **School Phone #** : ____________________

Parent(s)/ Legal Guardian : ____________________ **School Contact** : ____________________

: ____________________ **CLC Specialist** : ____________________

Address : ____________________ **Grade** : ____________________

Postal code : ____________________ **CBE Authorization Signed YES___ NO___**

Home Phone # : ____________________

Work Phone # : ____________________

Student's Alberta Health Care Number : ____________________

Name of Family Physician and/or Pediatrician : ____________________

Phone number of doctor(s) : ____________________

Alberta Children's Hospital Number : ____________________

IS THE STUDENT IN QUESTION:

Please rate the concern by circling a number on the scale 1-5: 1 represents "No concern" and 5 represents "High concern".

Disruptive in the classroom?	1	2	3	4	5
Underachieving academically?	1	2	3	4	5
Physically aggressive or violent?	1	2	3	4	5
Socially inappropriate with peers?	1	2	3	4	5
Emotionally restricted?	1	2	3	4	5
Appear sad?	1	2	3	4	5
Appear to have low self-esteem?	1	2	3	4	5
Often out of seat, fidgets or squirms?	1	2	3	4	5
Inattentive, distracted/distractible	1	2	3	4	5
Uncoordinated in fine motor skills?	1	2	3	4	5
Uncoordinated in gross motor skills?	1	2	3	4	5
Impaired in hearing?	1	2	3	4	5
Impaired in vision?	1	2	3	4	5
Fearful?	1	2	3	4	5
Avoidant?	1	2	3	4	5
Clingy?	1	2	3	4	5
Odd, bizarre or peculiar in behavior?	1	2	3	4	5
Stealing?	1	2	3	4	5
Bullying?	1	2	3	4	5
Display non-compliant behavior?	1	2	3	4	5
Appear neglected?	1	2	3	4	5
Appear abused?	1	2	3	4	5
Appear under stress?	1	2	3	4	5
Suicidal or self-harming?	1	2	3	4	5
Delayed in understanding or using language?	1	2	3	4	5
Appear to have health concerns: nutrition, allergies, circles under eyes, etc. Please Specify?	1	2	3	4	5

Other? Please Specify ____________________

OVER →

Additional Presenting Concerns:

Family Background/Genogram:

What questions are you hoping to have answered?

C.O.P.E. Team Recommendations:

The personal information on this form is collected in accordance with provisions as stipulated with the School Act and under the authority of Section 32(c) of Alberta's Freedom of information and Protection Act for the C.O.P.E. Program. If you have any questions about this consent form, please contact the C.O.P.E. Program at Parkdale Centre, 728 – 32nd St. N.W. T2N 2V9. Phone: 777-7240 ext. 2239; Fax 777-8103

November 4, 1999

C.O.P.E.
Community Outreach in Pediatrics/Psychiatry and Education
Parkdale Centre, 728 – 32 St. N.W.
Calgary, Alberta, Canada
T2N 2V9

Dear Doctor,

A shared concern amongst parents, educators and doctors is early identification and intervention for children experiencing difficulties with their learning or behavior in the classroom setting. The Calgary Regional Health Authority, the Calgary Board of Education and the Department of Pediatrics at the University of Calgary have a joint commitment to work with families to better understand these problems and develop workable solutions

To assist in getting accurate information the Division of Developmental Pediatrics is conducting a survey of elementary school students in certain areas of Calgary who are identified by the school as having behavioral/emotional difficulties. Health Canada and Alberta Health fund the research Project. The purpose of the survey is to determine if school based medical consultation is an effective and efficient mode of service delivery.

Your patient's participation entails meeting with staff in the COPE program for pediatric and/or child psychiatry consultation. You will be provided with written consultation reports following these appointments. In addition, we would greatly value any information you could provide us with prior to the consultation.

A Physician form is attached if you are in agreement with the need for further consultation. Please fill out the form and fax it to Vandora Moxam, the COPE Co-ordinator at 777-8103, or call 777-7240 ext. 2251 if you have any questions or would like to learn more about the research.

Thank you for your cooperation, and we would look forward to working with you in the coordination of care and follow-up of this patient.

Dr. Margaret E. Clarke, MD FRCPC
COPE, Program Director

STUDY

Physician Referral Form

C.O.P.E.

Community Outreach in Pediatrics / Psychiatry And Education Program

Please complete the following information when requesting assessment and consultation services for children and families with learning, behavioural and emotional challenges who have consented to participate in the C.O.P.E. research project.

Patient Demographics – Please stamp information

- What questions would you like answered as part of this referral?
- What type of service is the family looking for at this time and what have they accomplished?
- Are all family members willing to be involved in this assessment? YES ____ NO ____

AREAS OF CONCERN: Please indicate any and all areas of concern

Physical Health / Mental		Destructive to Property	
Family Issues		Theft	
Peer Relationships		Lying	
Separation / Custody		Losses / Depression / Withdrawal	
Speech – Language		Anxiety / Traumatic Events	
Fine / Gross Motor		Hallucinations / Traumatic Events	
Hearing / Vision		Eating Disorder / Body Image Concerns	
Odd / Unusual Behaviour		Substance Abuse	
Academic Performance		Sexual Abuse / Sexually Inappropriate	
Attention / Over-Activity		Physical Abuse	
Social Behaviour Problems		Neglect	
Aggression to People / Animals		Emotional Abuse	
Negative / Hostile / Defiant Behaviours		Domestic Abuse	

SEVERITY / URGENCY:

Situation not urgent ____
Situation requires attention within one month ____
Child is a danger to self and/or others / unpredictable ____

MEDICATIONS / ALLERGIES:

OTHER ASSESSMENTS COMPLETED:
Please indicate reports if available

____ Speech Therapy
____ Occupational Therapy
____ Community Health Nurse
____ Pediatrics
____ Social Services (Income support)
____ Other (specify)
____ Physiotherapy
____ Education
____ Home Care
____ Psychiatry
____ Child Welfare

RELEVANT MEDICAL PROBLEMS – LIST:

OTHER AGENCIES CURRENTLY INVOLVED WITH FAMILY – DOES FAMILY FIND INVOLVEMENT HELPFUL?

OTHER RELEVANT INFORMATION YOU WOULD LIKE TO ADD:

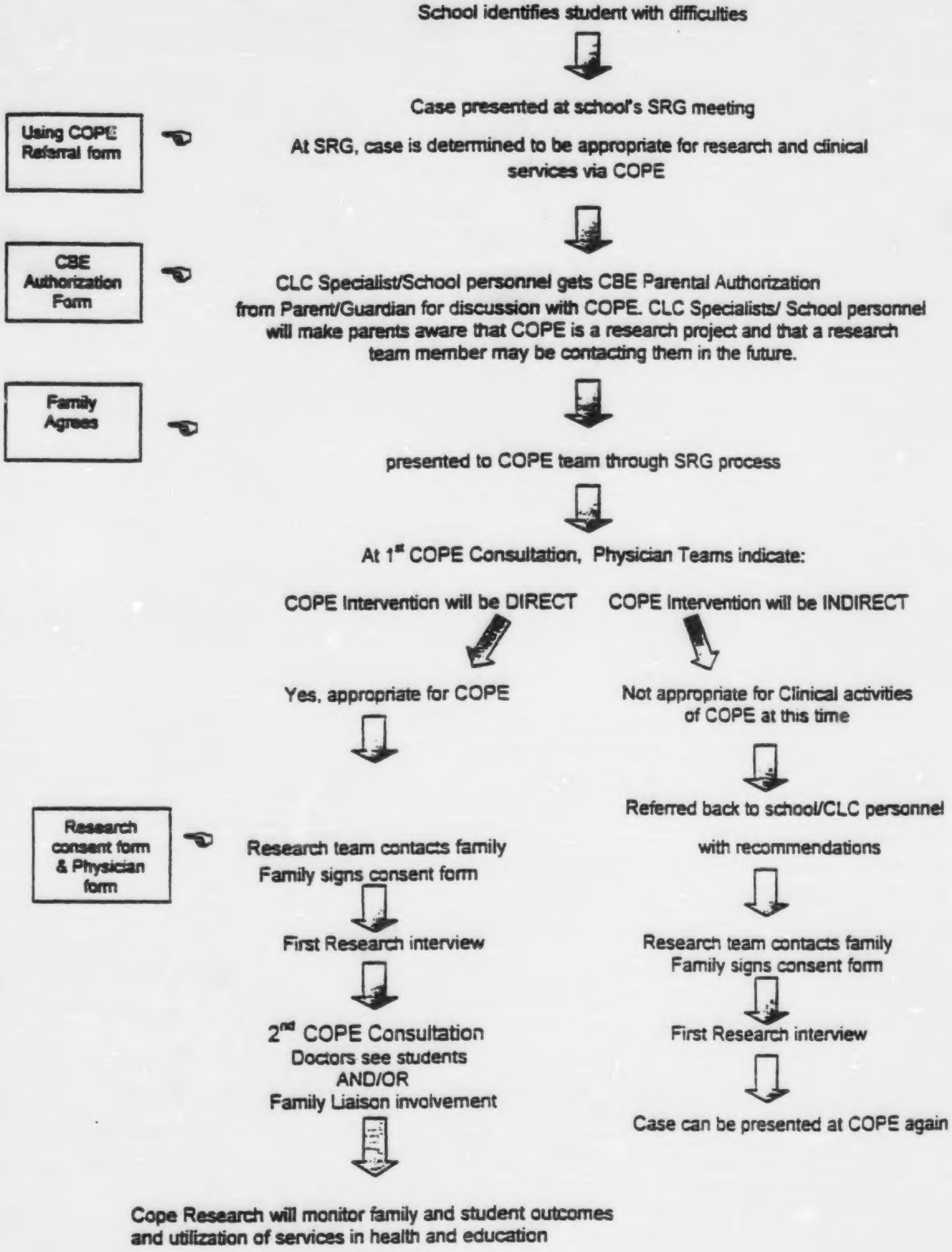
Name of child's regular physician ____________________
Address ____________________ Postal Code ____________
Practitioner ULI# ____________ Phone # ____________ FAX # ____________
Physician Signature ____________________ Date ____________

The personal information on this form is being collected in order to do a medical assessment regarding school learning difficulties, under authority of Section 32 c of the Freedom of Information and Protection of Privacy Act. If you have questions about the process to which this child is being referred please contact: Vandora Moxam , Coordinator COPE Program, Phone 777- 7240 (ext 2251)

THANK YOU. PLEASE FAX THIS FORM TO VANDORA MOXAM AT 777-8103

COPE RESEARCH REFERRAL PROCESS

FOR CLC 1, 5, 6, 8



School identifies student with difficulties

Case presented at school's SRG meeting

Using COPE Referral form

At SRG, case is determined to be appropriate for research and clinical services via COPE

CBE Authorization Form

CLC Specialist/School personnel gets CBE Parental Authorization from Parent/Guardian for discussion with COPE. CLC Specialists/ School personnel will make parents aware that COPE is a research project and that a research team member may be contacting them in the future.

Family Agrees

presented to COPE team through SRG process

At 1st COPE Consultation, Physician Teams indicate:

COPE Intervention will be DIRECT

Yes, appropriate for COPE

Research consent form & Physician form

Research team contacts family
Family signs consent form

First Research interview

2nd COPE Consultation
Doctors see students
AND/OR
Family Liaison involvement

Cope Research will monitor family and student outcomes and utilization of services in health and education

COPE Intervention will be INDIRECT

Not appropriate for Clinical activities of COPE at this time

Referred back to school/CLC personnel with recommendations

Research team contacts family
Family signs consent form

First Research interview

Case can be presented at COPE again

03-Feb-99 A-10

COPE RESEARCH REFERRAL PROCESS

FOR CLC 2, 3, 4, 7

School identifies student with difficulties

↓

Case presented at school SRG meeting

COPE Referral Form ☜ At SRG case is determined to be appropriate for Research Component of COPE as a control subject

↓

CBE Authorization ☜ CLC Specialist/School personnel talks with parents To describe COPE research Project and details regarding How research team will contact them.

↓

Research Team contacts Family

↓

Research Consent Form ☜ Research Consent signed

↓

Educators contacted by research team

Research Interviews

↓

SRG decides and makes recommendations for services as usual

COPE Research will monitor family and student outcomes and utilization of services in health and education

03-Feb-99

C.O.P.E.

Community Outreach in Pediatrics/Psychiatry and Education Program

A Typical COPE Profile

Based on referrals from the last year and in consultation with physicians and educators in the elementary schools, the following points profile a potential COPE candidate.

Lack of resources or ability to access resources in these areas:

- Positive parental input
- Disruptive in the classroom
- Underachieving academically
- Physically aggressive or violent
- Socially inappropriate with peers
- Emotionally restricted or sad, has low self-esteem
- Often out of seat, fidgety or squirmy
- Inattentive, distracted/distractible
- Uncoordinated in fine or gross motor skills
- Impaired in hearing or vision
- Fearful, avoidant or clingy
- Odd, bizarre or peculiar in behavior
- Inappropriate sexual in behavior or speech
- Stealing, bullying or non-compliant
- Suicidal or self-harming
- Apparently neglected, abused or appears to be under stress
- Delayed in understanding or using language
- Appears to have health concerns: nutrition, allergies, circles under eyes, etc.

COPE/school working relationship with students will be an essential component to the success of this initiative

Outline Referral Process

C.O.P.E.
Community Outreach In

Pediatrics/Psychiatry and Education
c/o Calgary Board of Education
Parkdale Centre
728 - 32 St. N.W.
Calgary, Alberta, Canada
T2N 2V9

Phone: 777-7240, ext. 2239
Fax: 777-8103

School-Based Medical Intervention

A shared concern amongst parents, educators and doctors is early identification and intervention for children experiencing difficulties with their learning or behavior in the classroom setting.

The COPE Program is designed to serve families whose elementary school-aged children are experiencing difficulties with their learning or behavior in the classroom setting.

COPE is a collaboration between the Calgary Regional Health Authority, the Calgary Board of Education and the Departments of Pediatrics at the University of Calgary. Together, they have a joint commitment to work with families to better understand these problems and develop workable solutions.

To get information about whether the COPE Program is effective, the Division of Developmental Pediatrics is conducting a survey of elementary school students in certain areas of Calgary who are identified by the school as having behavioral/emotional difficulties.

The Purpose of the Study:

To determine if school-based medical consultation is an effective and efficient mode of service delivery.

Parents, teachers and doctors want to find out about and help change the behavior of children who have learning problems at school. This is a study of how to make this work better in Calgary schools.

Schools have been assigned to "Study Groups" and "Control Groups". The main difference between these two groups is that the study group includes medical doctors in school-based discussions of students with behavioral or learning difficulties.

COPE Staff:

Vendora Moxam
COPE Coordinator
777-7240, ext.2251

Dr. Margaret Clarke
COPE Director
777-7240, ext. 2239

Mark Reckord
COPE Family Liaison
777-7240, ext.2222

Tanis Lowe
Office Administrator
777-7240, ext. 2239

Doctors Participating in the Program:
Dr. Susan Carpenter
Dr. Margaret Clarke
Dr. Neil Cooper
Dr. Allan Donsky
Dr. Geoff Fisher
Dr. Thiru Govender
Dr. Jean-Francois Lemay
Dr. Ted Prince
Dr. Pam Veale
Dr. Tim Yates

Researchers Participating in the Program:
Dr. Keith Archer
Dr. Lynn Bosetti
Elaine Foulkes

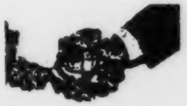
Participation in this study involves students and their parents filling out several questionnaires. Some participants will also be meeting with staff in the COPE Program for consultation regarding the student's medical, learning, or social and emotional needs. Teachers and educational Specialists will also be involved in the consultation.

We expect that by finding out about the needs of children having learning or behavioral problems in the classroom, and providing help at an earlier stage will result in improved learning and better coping skills.

Participant's responses will remain strictly confidential.

At the conclusion of the study, a summary of the findings will be made available to the participants in the study.

Health Canada and Alberta Health fund the research Project.



OUTLINE OF COPE PRINICPAL PACKAGE

COPE Brochure

A Typical COPE Profile

COPE Referral Form

CBE - COPE Consent Form

COPE Consent Form for Parents (* Research staff have the parents sign this.)

COPE Consent Form for Educators

COPE Research Referral Process

Letter from Research

Principal Questionnaire

Letter to Community Doctor from Dr. Clarke

Community Physician Referral Form

Proposal to Enhance and Evaluate COPE

List of Schools Participating in COPE

C.O.P.E.

Community Outreach in Pediatrics/Psychiatry and Education

A Typical COPE Profile

Based on referrals from the last year and in consultation with physicians and educators in the elementary schools, the following points profile a potential COPE candidate.

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- Inattentive, distracted/distractible
- Uncoordinated in fine or gross motor skills
- Impaired in hearing or vision
- Fearful, avoidant or clingy
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- Apparently neglected, abused or appears to be under stress
- Delayed in understanding or using language
- Appears to have health concerns: nutrition, allergies, circles under eyes, etc.

COPE/school working relationship with students will be an essential component to the success of this initiative

C.O.P.E.

Community Outreach in Pediatrics/Psychiatry and Education

COPE REFERRAL FORM

Student Name :____________________ **School** :____________________

D.O.B. :____________________ **School Phone #** :____________________

Parent(s)/ Legal Guardian :____________________ **School Contact** :____________________

:____________________ **CLC Specialist** :____________________

Address :____________________ **Grade** :____________________

Postal code :____________________ **CBE Authorization Signed YES___ NO___**

Home Phone # :____________________

Work Phone # :____________________

Student's Alberta Health Care Number :____________________

Name of Family Physician and/or Pediatrician :____________________

Phone number of doctor(s) :____________________

Alberta Children's Hospital Number :____________________

IS THE STUDENT IN QUESTION:

Please rate the concern by circling a number on the scale 1-5: 1 represents "No concern" and 5 represents "High concern".

Disruptive in the classroom?	1	2	3	4	5
Underachieving academically?	1	2	3	4	5
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Socially inappropriate with peers?	1	2	3	4	5
Emotionally restricted?	1	2	3	4	5
Appear sad?	1	2	3	4	5
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Often out of seat, fidgets or squirms?	1	2	3	4	5
Inattentive, distracted/distractible	1	2	3	4	5
Uncoordinated in fine motor skills?	1	2	3	4	5
Uncoordinated in gross motor skills?	1	2	3	4	5
Impaired in hearing?	1	2	3	4	5
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Clingy?	1	2	3	4	5
Odd, bizarre or peculiar in behavior?	1	2	3	4	5
Stealing?	1	2	3	4	5
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Suicidal or self-harming?	1	2	3	4	5
Delayed in understanding or using language?	1	2	3	4	5
Appear to have health concerns: nutrition, allergies, circles under eyes, etc. Please Specify?	1	2	3	4	5

Other? Please Specify ____

OVER →

A-16

Additional Presenting Concerns:

Family Background/Genogram:

What questions are you hoping to have answered?

C.O.P.E. Team Recommendations:

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November 4, 1999

SE-030 (1999/05)

Calgary Board of Education

Parental Authorization

Direction: *Authorization is a signed statement of informed consent to provide special assistance for the benefit of the student. Signature must be provided by the parent/guardian if the student has not reached the age of majority. If the student is eighteen years of age or older, the student must provide consent instead of parent/guardian.*

Student Identification Information

Student's Name *(Last)* *(First)* *(Initial)*

Date of Birth

Yr	Mo	Da

School

Teacher

Grade/Class

Consent (Indicate type ☐ of authorization.)

☐ I hereby consent to the provision of psychological assessment by and consultation with authorized staff employed by the Calgary Board of Education in regards to the exceptional needs of the aforenamed student.

I also acknowledge that I have been informed of the nature and intent of this assessment and I understand that school staff will subsequently review the results of this assessment with me and explain any forthcoming recommendations. It is understood that the psychologist will make the initial interpretation.

☒ I hereby consent to the release to the Calgary Board of Education, and to any duly authorized agent hereof, all the records, reports of examinations, and information of medical, psychiatric/psychological, and/or educational assessments or program rendered to the aforenamed student.

Community Outreach in Pediatrics/Psychiatry and Education (C.O.P.E.)

☒ I hereby authorize the Calgary Board of Education, and any duly authorized agent thereof, to release to:

Community Outreach in Pediatrics/Psychiatry and Education (C.O.P.E.)

Name of school, district, agency, person, etc.

all school records, report assessments, and information of medical, psychiatric, psychological, and/or educational assessments or program rendered to the aforenamed student.

Authorization Signatures

This consent and authorization will be in effect for the current school year.

Name of Consenting Person

Name and Role of School Official

Signature of Consenting Person

Signature of School Official

Date

Date

Please Return To:

Role of School Official

Telephone Number

Yr	Mo	Da

Address

C.O.P.E.
Community Outreach in Pediatrics / Psychiatry and Education Program
c/o Calgary Board of Education,
Parkdale Centre 728 – 32 Street N.W.
Calgary, AB, Canada
T2N 2V9

COPE Consent Form (For Parents/Guardians)

Research Project Title: COPE, Community Outreach in Pediatrics and Psychiatry in Education

Investigators:	Margaret E. Clarke, MD FRCPC COPE, Program Director	Keith Archer, PhD COPE, Research Director

Sponsor: Alberta Health

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Student's Name (Last) (First) (Initial)

___/___/___
Yr Mo Day

____
School Teacher Grade/Class

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There are minimal risks associated with your participation in this study, and perhaps considerable benefits.

Participation involves your child meeting with staff in the COPE program for consultation regarding your child's medical, learning, or social and emotional needs, and/or with teachers and program specialists for similar consultation at a school in your area. If you join the program in Nov 1998 to Feb, 1999 you will be asked to fill out one questionnaire which takes about 60 minutes to complete, and two more questionnaires, 4 months and 8 months later, that take about 30 minutes to complete. If you start the program between March 1999 and June 1999 you will be asked to fill out one questionnaire at the beginning, and one more questionnaire 4 months later.

We expect that by finding out about the needs of children having learning or behavior problems in the classroom, and doing something to help them, will result in improved learning, and better coping skills.

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This study will not require any financial costs to you or your family.

If you or your child suffer any injury as a result of being in this study, no financial compensation will be provided to you by Alberta Health, the University of Calgary, the Calgary Regional Health Authority, the Calgary Board of Education, the research and program staff. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

28-Jan-99

C.O.P.E.

Community Outreach in Pediatrics / Psychiatry and Education Program

Your involvement in this study is very important and valued. We cannot pay you to participate in this study. However, we can reimburse you, up to $15.00 per interview, for any costs that you have, such as bus fare or babysitting costs, to participate in the study.

To show that you have read the information above, and that you agree to be involved in the project, please check each of the boxes below that apply, and sign the consent form.

☐ I request that my child (named above) be referred to the COPE program for pediatric or child psychiatry consultation.

☐ I acknowledge that I have been informed of the nature and intent of this assessment and I understand that school and/or medical staff involved with this program will review the results of this assessment with me and explain any recommendations.

☐ I understand that I will be fully informed of the findings and recommendations.

☐ I provide consent for my child's doctor to disclose the information requested on page 4 of this form to the medical and research staff involved with this program.

☐ I provide consent for the Calgary Board of Education, and any duly authorized agent thereof, to release to the COPE program all school records, report assessments, and information of medical, psychiatric, psychological and/or educational assessments or program rendered to my child.

☐ I have read the information above. I understand the nature of the research, and I understand that as a participant in this study, my child will complete two or three interviews. I understand my child may withdraw from the study at any time, and this withdrawal will have no impact on his/her participation in this program. I consent to my child's participation in this study under these terms and conditions.

☐ I have read the information above. I understand the nature of the research, and I understand that as a participant in this study, I will complete two or three interviews. I understand that I may withdraw from the study at any time, and this withdrawal will have no impact on my child's participation in this program. I consent to participate in this study under these terms and conditions.

Your signature on this form indicates that you have understood to your satisfaction that information regarding participation in this research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Vandora Moxam, Program Coordinator, at 777-7240, ext. 2251

If you have questions about your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

Authorization signatures

Name of consenting Person	Name of Witness	Name of Research Staff Member
Signature of Consenting Person	Signature of Witness	Signature of Research Staff Member
Date	Date	Date

A copy of this consent form has been given to you to keep for your records and reference.

The investigator will, as appropriate, explain to your child the research and his or her involvement, and will seek his or her ongoing cooperation throughout the project.

The personal information contained on this form is collected in accordance with provisions as stipulated within the School Act and under the authority of Section 32© of Alberta's Freedom of Information and Protection of Privacy Act for the COPE Research project. If you have any questions about this consent for, please contact Vandora Moxam, Program Coordinator, COPE, Calgary Board of Education, Parkdale Centre, 728 – 32 St. N.W. T2N 2V9, 777-7240 ext 2251.

C.O.P.E.
Community Outreach in Pediatrics / Psychiatry and Education Program
c/o Calgary Board of Education,
Parkdale Centre 728 - 32 Street N.W.
Calgary, AB, Canada
T2N 2V9

COPE Consent Form (For Educators)

Research Project Title: COPE, Community Outreach in Pediatrics and Psychiatry in Education

Investigators:	Margaret E. Clarke, MD FRCPC COPE, Program Director	Keith Archer, Ph.D. COPE, Research Director

Sponsor: Alberta Health

Student Identification Information

This consent form a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Date of birth

____
Student's Name (Last) (First) (Initial)

___/___/___
Yr Mo Day

____
School Teacher Grade/Class

Purpose of the research: A shared concern among parent, educators and doctors is early identification and intervention for children experiencing difficulties with their learning or behaviour in the classroom setting. To assist in getting accurate information about this issue, this study is examining a group of elementary school students enrolled in the Calgary Board of Education, who have been identified as experiencing difficulties with their learning or behaviour in the classroom.

Description of procedures: The student, whose name appears on the top of this consent form, has been selected to participate in this project. The CLC specialist working with the school has contacted you regarding the need for further assessment of the student. This student will meet with staff in the COPE program for pediatric or child psychiatry consultation and/or with teachers and CLC specialists for consultation in a school in his/her area. This child will also be asked to complete several questionnaires about his or her attitudes and behaviour. In addition, you as an educator will be asked to complete several questionnaire about this child's behaviour and about family and school situations.

Research design: Schools have been randomly assigned to 'study groups' and 'control groups'. This student has been assigned to one of these groups based on the school he/she attends. We will reveal the group to which the student was assigned at the conclusion of the study.

Likelihood of discomforts, inconveniences and/or risks: We expect there to be little or no discomforts or inconveniences associated with participation in this study. Participation largely involves completing several questionnaires about current attitudes and current or past behaviours. Participants in the study will experience negligible risks associated with their participation, and some may experience considerable benefits.

What participation entails: Participation entails meeting with staff in the COPE program for pediatric or child psychiatry consultation and/or with teachers and CLC specialists for consultation is a school in his/her area. For participants recruited into the program between November 1, 1998 and Feb. 28, 1999, participation also involves completing one questionnaire of approximately 30 minutes upon recruitment, and two follow-up questionnaires of approximately 15 minutes each, at 4 month intervals. For participants recruited into the program between March 1, 1999 and June 30 1999, participation involves completing one questionnaire upon recruitment and one follow-up questionnaire at a 4 month interval.

28-Jan-99

Probability of benefits: The expectation is that early identification and intervention for children experiencing difficulties with their learning or behaviour in the classroom will result in improved learning and better coping skills.

Access to information and subject anonymity: Information gathered in this study will be made available to the research staff of the COPE project. The data will be stored securely, and no identifying information will be stored as part of the study data file. All respondents will have their identity remain confidential.

Information during the course of the research: Data from the research program will not be released during the course of the research (November 1, 1998 – February 28, 2000). At the conclusion of the project, a summary of the information learned will be made available to all participants in this project.

Financial costs. This study will impose no financial costs on participants or their families.

Compensation for injuries: In the event that you suffer any injury as a result of participating in this research, no financial compensation will be provided to you by Alberta Health, the University of Calgary, the Calgary Regional Health Authority, the Calgary Board of Education, the research and program staff. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

Please indicate that you have read the above and consent to participation in this project by signing this consent form.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in this research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Vandora Moxam, Program Coordinator, at 777-7240, ext. 2251

If you have questions about your rights as a possible participant in this research, please contact the Office of Medical Bio-ethics, Faculty of Medicine, University of Calgary, at 220-7990.

……

Authorization signatures

Name of consenting Person	**Name of Witness**	**Name of Research Staff Member**
Signature of Consenting Person	**Signature of Witness**	**Signature of Research Staff Member**
Date	**Date**	**Date**

A copy of this consent form has been given to you to keep for your records and reference.

The investigator will, as appropriate, explain to your child the research and his or her involvement, and will seek his or her ongoing cooperation throughout the project.

The personal information contained on this form is collected in accordance with provisions as stipulated within the School Act and under the authority of Section 32© of Alberta's Freedom of Information and Protection of Privacy Act for the COPE Research project. If you have any questions about this consent for, please contact Vandora Moxam, Program Coordinator, COPE, Calgary Board of Education, Parkdale Centre, 728 – 32 St. N.W. T2N 2V9, 777-7240 ext 2251.

Proposal to Enhance and Evaluate COPE

(Community Outreach in Pediatrics/Psychiatry and Education)

A SCHOOL BASED PRIMARY HEALTH CARE INITIATIVE

Submitted by: Margaret Clarke, MD, FRCPC,
Head, Developmental Pediatrics,
Alberta Children's Hospital
1820 Richmond Rd. S.W.,
Calgary, AB
T2T 5C7

Phone: (403) 541-7515
Fax: (403) 229-7649

1.0 Introduction

The early identification of children with emotional, behavioural and learning problems is recognized as an essential part of the promotion of psychosocial well-being and the prevention of chronic and social problems in adulthood.

The need to target intervention at populations where increased rates of determinants, such as poverty, are associated with a 3-4 fold increase in the prevalence of childhood mental disorders is consistently identified as a priority in the literature (Offord, et al, 1989). The reason most often cited for these directed interventions is that in spite of having significant rates of psychiatric disorders, children exposed to high levels of psychosocial adversity have lower utilization rates of preventative and outpatient mental health services (Offord, 1986). In a recent study in the United States, it was found 40% of inner city children were at risk for psychiatric disorder, only 11% of these children (at risk) had utilized mental health services (Zahner, et al, 1991).

Conversely, children living in these high risk communities, have significantly higher utilization of emergency room services and inpatient services for mental health disorders which are known to have lower treatment efficacy and much higher cost than outpatient services (Armbruster, et al, 1997). In Calgary, a recent needs assessment revealed that children and adolescents residing in high risk communities (defined as having a volume of social needs three times greater than the average community) had a utilization rate of 12 per thousand of emergency room services for a mental health diagnosis as compared to the standard utilization rate for children between 0-18 years of 7 per thousand (Clarke, 1997).

The most important barrier to early identification of mental health problems, especially in childhood populations at high risk, is lack of access to a primary health care system that can identify problems and refer on to appropriate services (Armbruster, et al, 1997). Many barriers to children in high risk communities accessing services have been identified including availability and acceptability. Moreover, children needing mental health services rarely seek it for themselves and are dependent on parents (who may have their own mental health problems) or teachers to recognize their needs and institute contact with appropriate services (Armbruster and Fallon, 1994).

Further barriers exist when educators who are often identifying children at high risk for psychiatric disorder are unable to access timely medical consultation regarding the nature of the problem and the best course of action.

Hence, the need to have effective early identification of mental health disorders in populations of children with higher rates of key determinants such as poverty or lack of parental education seems to be well justified. Although it has long been suggested that education and health could work together to address children's mental needs, especially in high risk communities, few programs in Canada have been implemented. The following section describes a pilot project that has been running in collaboration with the Calgary Board of Education since September 1997, called COPE – Community Outreach in Pediatrics/Psychiatry and Education.

2.0 Program Overview:

2.1 Program Goals and Description:

The goal of the program is to provide pediatric and child psychiatry outreach services to under served, disadvantaged children and to collaborate more closely with the schools around issues such as early identification and system access. **Figure 1** depicts the service delivery model offered by the COPE Program. The model has close collaboration between pediatric and child psychiatry medical personnel who work with education specialists to provide early identification, consultation, assessment and system access to at risk children. The program has seen approximately 130 children in various school settings in Calgary. One child psychiatrist and one developmental pediatrician have been working one half day per week in the schools, while two community developmental pediatrician have been working in the schools one half day per month. A second child psychiatrist has provided services to children with complex dual diagnoses such as mental retardation and mental health problems.

2.2 Objectives of the COPE Program:

The program has developed specific objectives which structure its services and are outlined below:

(1) Early identification of children with emotional and behavioral problems.

(2) Early medical consultation and provision of comprehensive assessment of psychosocial and health status to better match needs and interventions.

(3) Improvement of access and linkages to existing services.

(4) More effective utilization of health and education resources to identify problems and direct children to appropriate interventions.

(5) Improvement in psychosocial outcomes of children served in the program.

2.3 Program Enhancements and Need to Evaluate:

The experiences in the pilot program have provided the impetus to put forward this proposal to enhance the COPE service delivery model and to evaluate the effectiveness of this model. The program enhancements that have been recommended by the educators and physicians working in the program include the following:

(1) The program be targeted at schools in communities known to have a significantly higher volume of need and lower probability for regular system access.

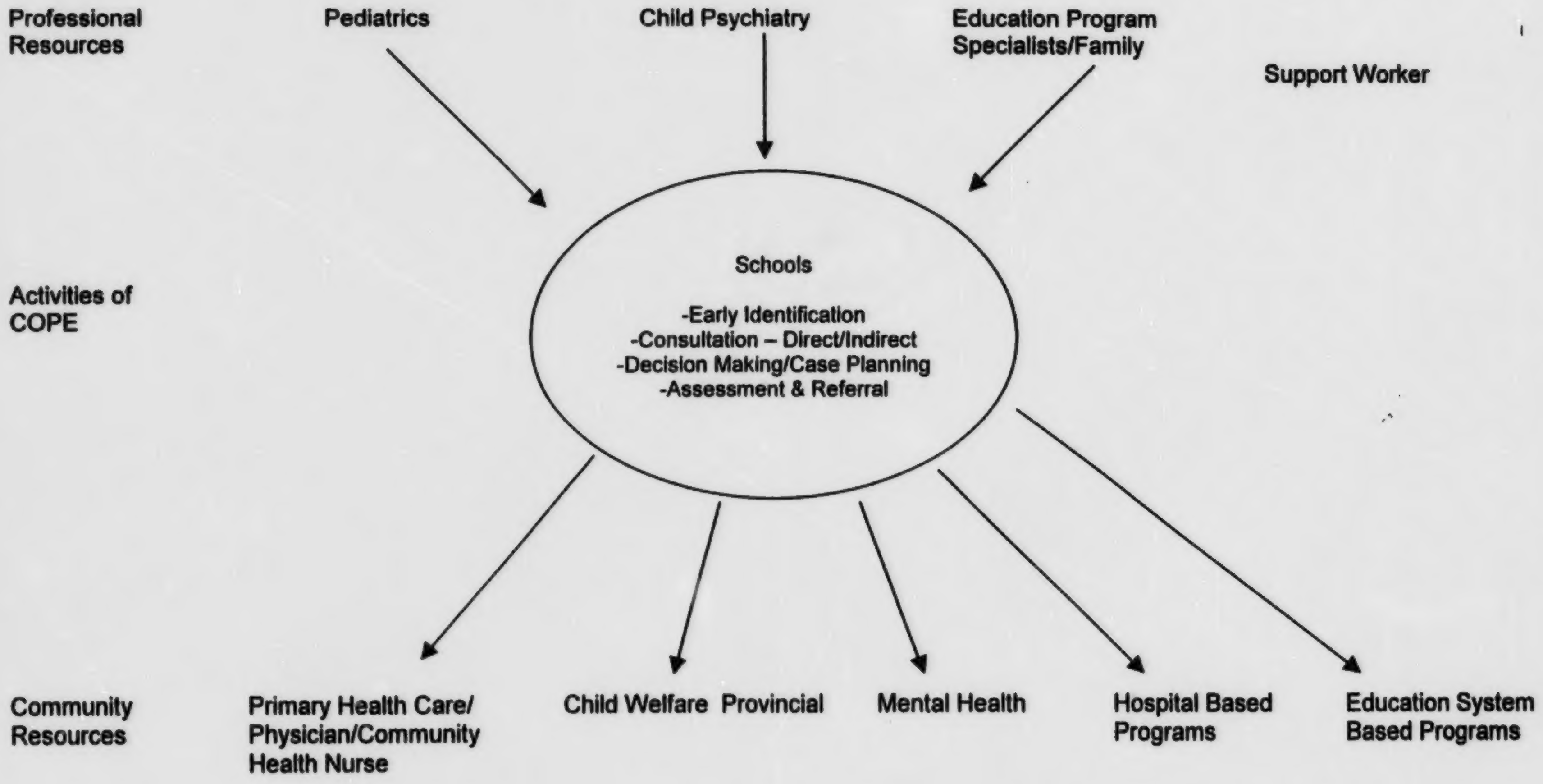
(2) Establish Implementation Advisory Committee with members from Community Health, Community Medical Practice, Provincial Mental Health, Hospital based programs (e.g. intake) as well as parents and educators from the communities involved to aid in the development of linkages between the project and community service providers and generally to provide consultation to the project.

(3) Pediatricians and child psychiatrists on-site at the same time to allow for cross consultation on difficult cases.

(4) A family support worker be a regular part of the team to provide follow-up and assist high risk families in system access and linkages to primary health providers.

(5) Set up a primary health provider network for COPE families who so not have regular physicians who would provide regular interventions and follow-up.

Figure 1. OVERVIEW OF COPE SERVICE DELIVERY MODEL


Professional Resources
Pediatrics
Child Psychiatry
Education Program Specialists/Family
Support Worker
Activities of COPE
Schools
-Early Identification
-Consultation – Direct/Indirect
-Decision Making/Case Planning
-Assessment & Referral
Community Resources
Primary Health Care/ Physician/Community Health Nurse
Child Welfare Provincial
Mental Health
Hospital Based Programs
Education System Based Programs

The service delivery team would be managed by a full-time coordinator who would be responsible for liaison wit the participating schools and also provide liaison with physicians involved in the program. The coordinator would also work with the program specialists to identify subjects for the control and comparison groups. A full-time family support worker would work under the supervision of the coordinator and in conjunction with physician teams to provide follow-up and assistance to families in the COPE Program

The COPE Medical Team consists of seasoned clinicians in Child Psychiatry, Developmental Pediatrics and General Pediatrics with a wide variety of interests. They are as follows:

Child Psychiatry:

Dr. Susan Carpenter, special interests – autism, mental retardation.

Dr, Tim Yates, special interests – early intervention, emotional disorders, comorbidities of Attention Deficit Disorder.

Pediatrics:

Dr. Margaret Clarke, special interests – autism, comorbidities of Attention Deficit Disorder.

Dr. Neil Cooper, special interests – child abuse, community based interventions for developmental concerns.

Dr. Ted Prince, special interests – pediatric rehabilitation, comorbidities of Attention Deficit Disorder.

The COPE medical team will also include Dr. Pam Veale, Fellow, Developmental Pediatrics and likely other medical resident trainees.

Full-time secretarial support would be required to support both the research and clinical aspects of this project.

3.6 Approval from Host Organization

The Calgary Board of Education provided endorsement of the pilot project and has given verbal approval (Mr. Jim Dean, Superintendent of Student Services) to proceed with this proposal to evaluate the COPE Program.

TABLE 1. Program Objectives, Research Questions and Research Strategies

OBJECTIVE	RESEARCH QUESTIONS	RESEARCH STRATEGIES
Early identification of children with emotional and behavioural problems	Do educators in COPE Program develop better knowledge about identification of children with mental problems? Does early and better identification lead to early and better intervention? Do children in the COPE Program have a broader range of difficulties identified? (i.e. more subtle problems such as depression)	● Interview of teacher, principal and specialists knowledge regarding key determinants and methods of identification of mental health problems pre- and one per year post-COPE implementation and in high risk control group schools. ● Comparison of length of time between identification and access to service intervention in COPE, high risk control and low risk comparison. ● Comparison of COPE group diagnostic profile on standardized behaviour inventory to children in high risk control and low risk comparison groups at point of intake to the study.
Early medical consultation – provision of comprehensive assessment to better match needs and interventions.	Do children seen through COPE Program attend and follow through on recommended interventions at a higher rate? Are families directly seen through the COPE Program more knowledgeable about their children's problems and the reasons why they are referred to a particular service?	Comparison between COPE and high risk control groups on: ● parent and intervention provider's opinion regarding referral appropriateness. ● parent knowledge of why particular intervention is recommended. ● rate of attendance and follow through or recommended interventions
Improved access and linkages to resources	Do children seen in COPE Program have better access to programs and services? Are children identified as having urgent need through the COPE Program seen more quickly by the appropriate system?	Comparison between COPE, high risk control and low risk comparison on: ● length of time between identification and access to service. ● type and range of services accessed ● length of time to be seen if identified as urgent.
More effective utilization of health and educational resources to identify problems and direct to intervention.	Does COPE Program lead to more effective utilization of resources, to identify and direct patients to interventions?	In COPE, high risk control and low risk comparison group: ● track and compare numbers and types of professionals involved with family via parent interview. ● track and compare via parent interview use of social services, emergency room and medical services. ● track and compare utilization of hospital resources (i.e. psychology) via Children's Hospital database [SRS]).
Improvement in psychosocial outcomes	Do children seen through the COPE Program have improved psychosocial outcomes?	●Administration of standardized behaviour instrument at the point of identification and at standard follow-up intervals in COPE and high risk control and low risk comparison groups (parent, teacher and child, when appropriate). ● Track and compare visits to emergency room and nature of diagnostic concern in COPE versus high risk control and low risk comparison group.

5.0 Summary of Project:

5.1 Implications for Primary Health Care:

This proposal has described an enhancement and evaluation of an innovative primary care initiative that provides school-based early identification and intervention for the mental health problems of children and families "at the school house door" to provide medical consultation soon after problem identification that is both accessible and acceptable. The program promotes inter-professional (pediatrics and psychiatry) as well as intersectoral collaboration to address patient needs in the most timely and cost effective manner possible. The COPE Program has been implemented without major redesign of either health or educational services.

5.2 Anticipate Outcomes and Key Learnings:

The anticipated outcome is that designing a service delivery model that will provide earlier identification of childhood mental health disorders should ultimately improve patient outcome and reduce long-term social and health morbidities associated with late identification of mental health disorders (e.g. suicide, anti-social behaviour).

The opportunity to evaluate and compare patient outcomes and service utilization patterns should also benefit tertiary service providers in more carefully directing their scarce resources. The project will also further knowledge regarding the key determinants of childhood mental health disorders. The information obtained from this project will aid both educators and health care providers in developing prevention and health promotion activities.

The project is being proposed at a time where regional strategies for child mental health and child welfare are being developed. The opportunity to evaluate a service delivery model, that has been used successfully in the United States, in an urban Canadian setting will be beneficial for future planning and intersectoral cooperation between health, education and child welfare. The project will also provide insight into the linkages necessary to ensure timely access for children and families needing mental health services and will identify barriers present in the current system which prevent these needs from being addressed.

It is anticipated that the school based medical consultation model could be expanded to become a complete mental health multidisciplinary team including all disciplines working in child health services in Region 4.

5.3 Transferability:

Calgary and Region 4 have a representative mix of community needs and community programs. Hence, the findings from this project should be transferable to other urban Canadian settings. In addition the project will use measures of child, family and social functioning from the National Longitudinal Survey for Children so that results from this study can be readily compared with national benchmarks.

6.0 References:

Armbruster, P., Gerstein, S., and Fallon, T. (1997). Bridging the Gap Between Service Need and Service Utilization: A School Based Mental Health Program. Community Mental Health Journal, Vol. 33, No. 3, 199 – 209.

Armbruster, P., and Fallon, T. (1994). Clinical, Socio-Demographic and Systems Risk Factors for Attrition in a Children's Mental Health Clinic. American Journal of Orthopsychiatry, 64(4), 577 – 585.

Clarke, M.E., (1997). Identification of Need and Analysis of Service Utilization Patterns in Child Abuse, Developmental and Mental Health Services. Unpublished report.

Offord, D., Boyle, M. and Racine, Y. (1984). Ontario Child Health Study: Children at Risk, Toronto: Queens Printer for Ontario.

Offord, D. (1986). Ontario Child Health Study: Summary of Initial Findings. Toronto: Queens Printer for Ontario.

Zahner, G., Dawe/Kiewicz, W., DeFrancesco, J.J. and Adnopoz, J. (1991). Children's Mental Health Service Needs and Utilization Patterns in an Urban Community: An Epidemiological Assessment. Journal of the American Academy of Child and Adolescent Psychiatry, 31:5, 951 – 960.

STUDY GROUP

CLC 1

Bowcroft
Belvedere-Parkway *(Spec. selection)*

Brentwood
Dalhousie
Marion Carson
Simons Valley
***Captain John Palliser

CLC 5

Earl Grey
Elbow Park

Jennie Elliot
King Edward
Rideau Park
Sunalta
Ogden*(Spec. Selection)*
Ramsay
Connaught
William Reid
Altadore
Richmond
Sherwood
***Clem Gardner

CLC 6

Andrew Sibbald
Fish Creek

Haultain Memorial
Riverbend
Acadia *(Specialist Selection)*

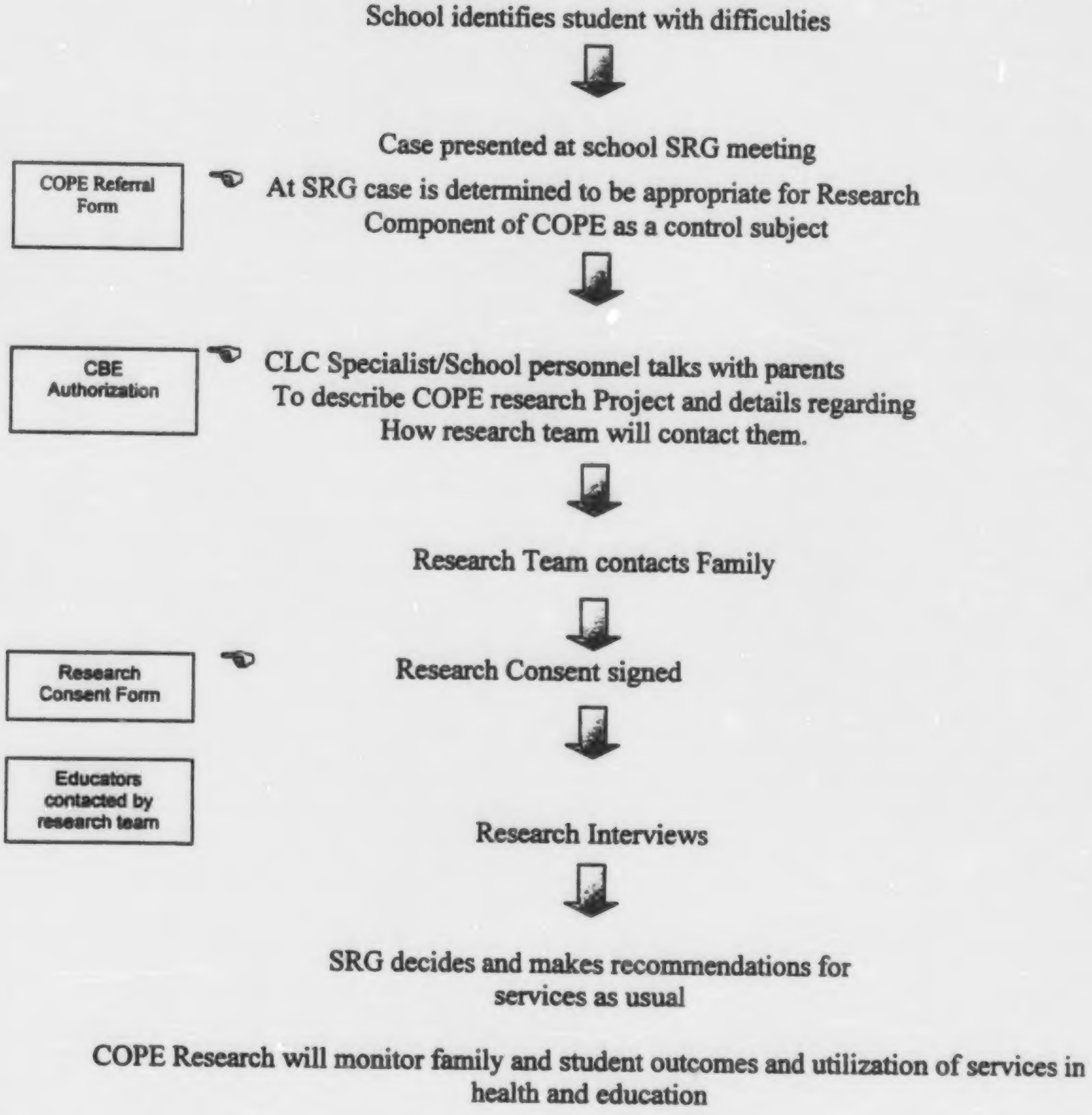
Queensland Downs
Le Roi Daniels
Andrew Davison
McKenzie Lake
Alice M. Curtis
Midnapore

CLC 8

Albert Park *(spec. selection)*
Colonel Walker
David D. Oughton
James Short Memorial
Keeler
Mountain View
Roland Michener
G.W. Skene

C.O.P.E. Control Group Referral Process

COPE RESEARCH REFERRAL PROCESS
FOR CLC 2, 3, 4, 7



School identifies student with difficulties

Case presented at school SRG meeting

COPE Referral Form

☞ At SRG case is determined to be appropriate for Research Component of COPE as a control subject

CBE Authorization

☞ CLC Specialist/School personnel talks with parents To describe COPE research Project and details regarding How research team will contact them.

Research Team contacts Family

Research Consent Form

☞ Research Consent signed

Educators contacted by research team

Research Interviews

SRG decides and makes recommendations for services as usual

COPE Research will monitor family and student outcomes and utilization of services in health and education

03-Feb-99

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List of C.O.P.E. Medical Equipment

COPE MEDICAL EQUIPMENT

- Stethoscope
- Child & Adult Inflation Systems & Velcuffs
- B.P. Aneroid, Pocket Model
- Otoscope Speculas (2.5mm & 4mm)
- Percussion Hammer
- Tongue Depressors
- Portable Diagnostic Kit

Information Tracked in the C.O.P.E. Database

INFORMATION TRACKED IN THE COPE DATABASE

DEMOGRAPHIC INFO.:

- Child Name
- Date of birth
- Address / Postal Code
- Home phone
- Parent(s) / Guardian(s)
- Parent(s) / Guardian(s) work phone number(s)
- Alberta Health Care number

SCHOOL INFO:

- CLC
- Referring school
- Present school
- School contact person
- Principal
- Referring CLC specialist
- Grade the child was in when referred to the program
- CBE Parental Authorization Form (Date received)

COPE INFO:

- Child accepted during ***Research Period*** (before Nov./99) or ***Post Research Period*** (after Nov./99)
- Screening date
- COPE Consent Form (Date received)
- Family Physician (name)
- Family Physician Referral Form (Date received)
- COPE Liaison involvement (yes or no)
- Number of pediatric consultations per child
- Number of psychiatric consultations per child
- List of the COPE physicians each child has seen and how many times
- List of Physician appointments (date[s], time[s], place[s], with which dr.[s], attendees, etc.)
- Checklist of which dictations have been sent (1 per consultation usually)
- Family dropped out of program (yes / no) – details if yes
- Number of no-shows (when family doesn't show up at appointment)
- Requires follow-up (yes / no)
- When follow-up is required (approximate time period)
- Follow-up completed (date)
- Cancelled appointments (details – why, by whom, etc.)
- Child moved schools (details if yes)
- Case closed (date)
- Extra Information
- Intervention Outcome (i.e. Seen by ACH, Moved away, withdrew from COPE, Case Closed – success [date], etc)
- Research Information (Dates of research interviews with parent / child, if family withdrew from research but not COPE, etc.)

Template of a Working File

COPE FILES

FAMILY PHYSICIAN:

☑ Physician Referral Form Received (DATE) Dec. 17/99 ☑ Recv'd **BEFORE** 1st Consult with Dr.

☐ Recv'd **AFTER** 1st Consult with Dr.

Name of Family Physician: Dr. Uni Number

Physician Phone: 888-1234 Physician Fax: 888-1235

DOCTOR CONSULTS / APPOINTMENTS:

Appt. #	DATE	TIME	PLACE	DOCTOR
1	Mar. 25/00	8:30 am	School #8	Dr. A
2	Jan. 6/00	10:00am	School #8	Dr. A
3				
4				
5				
6				

CONSULT REPORTS:

☑ **1st Consult report sent out (DATE)** April 5, 2000
- cc. ☑ COPE File
- cc. ☑ Consulting Physician
- cc. ☑ Parents
- cc. ☑ Family Physician
- cc. ☐ Other(s) ______

☐ **2nd Consult report sent out (DATE)** ______
- cc. ☐ COPE File
- cc. ☐ Consulting Physician
- cc. ☐ Parents
- cc. ☐ Family Physician
- cc. ☐ Other(s) ______

☐ **3rd Consult report sent out (DATE)** ______
- cc. ☐ COPE File
- cc. ☐ Consulting Physician
- cc. ☐ Parents
- cc. ☐ Family Physician
- cc. ☐ Other(s) ______

☐ **4th Consult report sent out (DATE)** ______
- cc. ☐ COPE File
- cc. ☐ Consulting Physician
- cc. ☐ Parents
- cc. ☐ Family Physician
- cc. ☐ Other(s) ______

☐ **5th Consult report sent out (DATE)** ______
- cc. ☐ COPE File
- cc. ☐ Consulting Physician
- cc. ☐ Parents
- cc. ☐ Family Physician
- cc. ☐ Other(s) ______

☐ **6th Consult report sent out (DATE)** ______
- cc. ☐ COPE File
- cc. ☐ Consulting Physician
- cc. ☐ Parents
- cc. ☐ Family Physician
- cc. ☐ Other(s) ______

OVER →

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LAB TESTS ORDERED:

TYPE OF LAB TEST	DATE TEST ORDERED	DR. THAT ORDERED TEST	DATE RESULTS RECV'D	Dr. REVIEWED RESULTS
Hearing	Mar. 25/00	Dr. A	April 10/00	☑
				☐
				☐
				☐
				☐
				☐
				☐
				☐

MOVED:

New School: ______________________ date: __________

Contact: ______________________ date: __________

Introduced to COPE (DATE): __________

Recorded in Database: ______________ date: __________

IMPORTANT CONTACT INFO:

* Parents are separated - send all reports to dad:

Joe Blow

# 2, 2222-22 St. N.W.

T1A 2B3

LOW, Joe

June 6/00

r.26/00 - Called school - LIM to set up follow-up appt. on [illegible]
@10:00am @ school #5.

June 6/00

Mr.30/00 - Jane Doe (teacher) called back - dad said [illegible] @ 10:00am
is good.

attending is ☑ family
☑ school
☑ CLC Specialist - LIM ē specialist on Mar.31/00
☑ Dr. A - notified Mar.26/00

REPORTS

&

DOCTOR'S CONSULT. NOTES

A-39

COPE
Community Outreach in Pediatrics/Psychiatry and Education Program
Parkdale Centre
728 – 32 Street N.W., Calgary, AB T2N 2V9
Phone: 777-7240, ext. 2239; Fax: 777-8103

CONFIDENTIAL

DATE: March 25, 2000

RE: BLOW, Joseph
DOB: January 1, 1980
SCHOOL: School #1

Those Present: Dr. A., COPE Staff Member Name, Jane Doe (Teacher @ School #1), Joe Blow (father), Jenny Blow (mom)

SCHOOL HISTORY:

MEDICAL HISTORY:

QUESTIONS RAISED BY THE SCHOOL:

FAMILY BACKGROUND:

IMPRESSION:

RECOMMENDATIONS:

Sincerely yours,

Dr. A., COPE Pediatrician

cc: Dr. A.
C.O.P.E. File
Joe Blow (father)
Dr. U. Number

G012(11/99)

Calgary Board of Education

COPE CONSULTATION FORM

Community Outreach in Pediatrics/Psychiatry and Education Program

School Support Services

Parkdale Centre
728 – 32 Street NW, Calgary AB T2N 2V9
Phone: 777-7240, ext. 2239; Fax 777-8103

Date: Mar. 25/00 Student ID#: ______ School: School # 1

Present: Dr. A., COPE staff member name, school contact name, Joe Blow (dad), Jane Doe (mom)

Form Completed By: COPE staff member name

Student Name: BLOW, Joe Grade: 1 D.O.B.: 80/01/01

Phone: 888-1111 Alberta Health Care #: ______

Address: 2, 2222 - 22 St. N.W. T1A 2B3

Recommendations from Consultation (Action Plan):	Facilitator
Have Hearing Tested	COPE
Psych. Assessment	School
Joe join Boys & Girls Club to learn more about social skills, etc.	Parents
Book follow-up meeting in June, 2000 to review recommendations & Audiology report	COPE

I, being the parent/legal guardian with the proper legal authority, have read the information contained on this form and do hereby consent on behalf of my child/ward to the use and disclosure (including a copy on my child's/ward's student record) of the personal information collected for the purpose of having all parties informed of recommendations and actions made at this COPE consultation.

Joe Blow
Name (please print)

Signature

March 25, 2000
Date

Authorization

The personal information on this form is collected in accordance with provisions as stipulated with the School Act, and under the authority of Section 32(c) of Alberta's Freedom of Information and Protection Act for the COPE (Community Outreach in Pediatrics/Psychiatry and Education) Program. If you have any questions about this consent form, please contact the COPE Program at Parkdale Centre, 728 – 32nd Street NW, T2N 2V9. Phone: 777-7240, ext. 2239; Fax 777-8103.

cc: COPE Program (White copy), School (Pink Copy), Parent (Yellow Copy), COPE Doctor (Goldenrod Copy)

A-12

C.O.P.E.
Community Outreach in Pediatrics/Psychiatry and Education

FAXES

LETTERS

ETC..

A-43

Parkdale Centre
728 - 32 St. N.W.
Calgary, Alberta
T2N 2V9
Phone: 777-7240, ext. 2239
Fax: 777-8103

C.O.P.E.

FAXED
JUN 15 2000

Fax

To:	Jane Doe – Teacher @ School #1	**From:**	COPE Staff Member Name
Fax:	###-####	**Date:**	June 15, 2000
Phone:	###-####	**Pages:**	~~1~~ 3
Re:	BLOW, Joe	**CC:**	

☐ **Urgent** ☑ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

•Comments:

In response to your fax earlier today, here is a copy of the

SCHOOL#1

facsimile transmittal

To: COPE Staff Member Name **Fax:** 777-8103

From: Jane Doe **Date:** 06/15/00

Re: BLOW, Joe **Pages:** 1

CC:

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☑ **Please Reply** ☐ **Please Recycle**

We are looking for information on In response to your fax earlier today, here is a copy of the

C.O.P.E.
Community Outreach in Pediatrics/Psychiatry and Education

TEST RESULTS

&

Miscellaneous Information

A-46

Alberta Children's Hospital
AUDIOLOGY REPORT

RE: **BLOW, Joseph**

Requisitioned by: Dr. A.

Completed by: [redacted]

[redacted]

[redacted]

CBE
PSYCHOEDUCATIONAL ASSESSMENT

RE: **BLOW, Joseph**

C.O.P.E.
Community Outreach in Pediatrics/Psychiatry and Education

AUTHORIZATION FORMS

&

PHYSICIAN REFERRAL FORM

A-49

SE-030 (1999/05)

Calgary Board of Education

Parental Authorization

Direction: Authorization is a signed statement of informed consent to provide special assistance for the benefit of the student. Signature must be provided by the parent/guardian if the student has not reached the age of majority. If the student is eighteen years of age or older, the student must provide consent instead of parent/guardian.

Student Identification Information

Student's Name *(Last)*: Blow
(First): Joseph
(Initial): K.

Date of Birth		
Yr	Mo	Da
80	01	01

School: School #1
Teacher: Jane Doe
Grade/Class:

Consent (Indicate type ☐ of authorization.)

☐ I hereby consent to the provision of psychological assessment by and consultation with authorized staff employed by the Calgary Board of Education in regards to the exceptional needs of the aforenamed student.

I also acknowledge that I have been informed of the nature and intent of this assessment and I understand that school staff will subsequently review the results of this assessment with me and explain any forthcoming recommendations. It is understood that the psychologist will make the initial interpretation.

☒ I hereby consent to the release to the Calgary Board of Education, and to any duly authorized agent hereof, all the records, reports of examinations, and information of medical, psychiatric/psychological, and/or educational assessments or program rendered to the aforenamed student.

Community Outreach in Pediatrics/Psychiatry and Education (C.O.P.E.)

☒ I hereby authorize the Calgary Board of Education, and any duly authorized agent thereof, to release to:

Community Outreach in Pediatrics/Psychiatry and Education (C.O.P.E.)
Name of school, district, agency, person, etc.

all school records, report assessments, and information of medical, psychiatric, psychological, and/or educational assessments or program rendered to the aforenamed student.

Authorization Signatures

This consent and authorization will be in effect for the current school year.

Name of Consenting Person: Joe Blow Sr.
Signature of Consenting Person:
Date: Mar. 5/00

Name and Role of School Official: Jane Doe
Signature of School Official: Jane Doe.
Date: Mar. 5/00

Please Return To:

Role of School Official:
Telephone Number:
Address:

Yr	Mo	Da

G014(11/99)

Calgary Board of Education

COPE CONSENT FORM

Community Outreach in Pediatrics/Psychiatry and Education Program

School Support Services

Parkdale Centre
728 – 32 Street NW, Calgary AB T2N 2V9
Phone: 777-7240, ext. 2239; Fax: 777-8103

Margaret E. Clarke, MD, FRCPC
COPE, Program Director

Sponsor: Alberta Health

By signing this consent form, you consent for you and your child to participate in the COPE Program.

Student Identification Information

Student's Name (Last): BLOW
(First): Joseph
(Initial): K.
Date of Birth: Year 80 / Month 01 / Day 01

School: School #1
Teacher: Jane Doe
Grade/Class: 1

The COPE Program is designed to serve families whose elementary school-aged children are experiencing difficulties with their learning or behaviour in the school setting.

COPE is a collaboration between the Calgary Regional Health Authority, the Calgary Board of Education and the Department of Pediatrics at the University of Calgary. Together, they have a joint commitment to work with families to better understand these problems and develop workable solutions.

Participation in the COPE Program may involve you and your child meeting with school personnel and COPE staff for consultation regarding your child's medical, learning, social and/or emotional needs.

If you or your child suffer any injury as a result of being in this program, no financial compensation will be provided to you by Alberta Health, the University of Calgary, the Calgary Regional Health Authority, the Calgary Board of Education or program staff. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

To show that you have read the information above, and that you agree to be involved in the project, please check each of the boxes below that apply, and sign the consent form.

☑ I request that my child (named above) be referred to the COPE program for pediatric and/or child psychiatry consultation.

☑ I acknowledge that I have been informed of the nature and intent of this assessment and I understand that the medical or COPE staff involved with this program will review the results of this assessment with me and a school representative, and explain any recommendations.

☑ I provide consent for my child's doctor to disclose the information requested on the physician form to the medical and COPE staff involved with this program.

☑ I provide consent for the Calgary Board of Education, and any duly authorized agent thereof, to release to the COPE program school records, assessment reports and information of medical, psychiatric, psychological and/or educational assessments or program rendered to my child.

☑ I consent to be contacted by a COPE representative to provide feedback on my family's involvement with the COPE Program.

NOTE: Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in this Program. Your signature also indicates that you have the proper legal authority to provide this consent.

If you have further questions concerning matters related to this program, please contact: COPE Program, 777-7240, extension 2239.

Authorization Signatures

Joe Blow
Name of Legal Guardian (please print)

Signature of Legal Guardian

Mar. 5/00
Date

Jane Doe
Name and Role of Witness (please print)

Jane Doe
Signature of Witness

Mar. 5/00
Date

Authorization

The personal information on this form is collected in accordance with provisions as stipulated with the School Act, and under the authority of Section 32(c) of Alberta's Freedom of Information and Protection Act for the COPE Program. If you have any questions about this consent form, please contact the COPE Program at Parkdale Centre, 728 – 32nd Street NW, T2N 2V9. Phone: 777-7240, ext. 2239; Fax 777-8103.

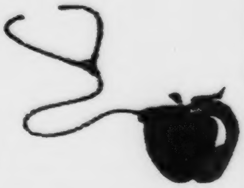
November 12, 1999

G015 (11/99)

Physician Referral Form – COPE

Community Outreach in Pediatrics/Psychiatry and Education Program

Please complete the following information when requesting assessment and consultation services for children and families with learning, behavioural and emotional challenges who have consented to participate in the COPE project.



Patient Demographics – Please stamp information

BLOW, Joseph
D.O.B. 80/01/01

- What questions would you like answered as part of this referral?
- What type of service is the family looking for at this time, and what have they accomplished?
- Are all family members willing to be involved in this assessment? ☐ Yes ☐ No

AREAS OF CONCERN: Please indicate any and all areas of concern.

☐ Physical/Mental Health
☐ Family Issues
☐ Peer Relationships
☐ Separation/Custody
☐ Speech–Language
☐ Fine/Gross Motor
☐ Hearing/Vision
☐ Odd/Unusual Behaviour
☐ Academic Performance
☐ Attention/Over-Activity
☐ Social Behaviour Problems
☐ Aggression to People/Animals
☐ Negative/Hostile/Defiant Behaviours
☐ Destructive to Property
☐ Theft
☐ Lying
☐ Losses/Depression/Withdrawal
☐ Anxiety/Traumatic Events
☐ Hallucinations/Traumatic Events
☐ Eating Disorder/Body Image Concerns
☐ Substance Abuse
☐ Sexual Abuse/Sexually Inappropriate
☐ Physical Abuse
☐ Neglect
☐ Emotional Abuse
☐ Domestic Abuse

SEVERITY/URGENCY:

☐ Situation not urgent
☐ Situation requires attention within one month
☐ Child is a danger to self and/or others/unpredictable

MEDICATIONS/ALLERGIES:

OTHER ASSESSMENTS COMPLETED:
Please indicate reports if available

☐ Speech Therapy
☐ Occupational Therapy
☐ Community Health Nurse
☐ Pediatrics
☐ Social Services (income support)
☐ Other
☐ Physiotherapy
☐ Education
☐ Home Care
☐ Psychiatry
☐ Child Welfare

RELEVANT MEDICAL PROGRAMS – LIST

OTHER AGENCIES CURRENTLY INVOLVED WITH FAMILY – DOES FAMILY FIND INVOLVEMENT HELPFUL?

OTHER RELEVANT INFORMATION YOU WOULD LIKE TO ADD:

Name of child's regular physician: Dr. Uni Number
Address: 11, 111 – 11 Ave. S.W.
Postal Code: T1A 3B4
Practitioner ULI#:
Phone #: 888-1234
Fax #: 888-1235
Physician Signature: Dr. Uni Number
Date: Mar. 1/00

Authorization

The personal information on this form is being collected in order to do a medical assessment regarding school learning difficulties, under authority of Section 32 c of the Alberta Freedom of Information and Protection of Privacy Act. If you have any questions about the program to which this child is being referred, please contact: The COPE Program, Phone 777-7240, extension 2239.

Thank you. Please fax this form to the COPE Program at 777-8103.

C.O.P.E.

Community Outreach in Pediatrics/Psychiatry and Education

COPE REFERRAL FORMS

&

SCREENING NOTES

December 17, 1999
~~[illegible]~~

3LOW, Joseph

tes :

ecommendations :

e pediatrician

ch. testing

etc... - -

G013(11/99)

Calgary Board of Education

COPE REFERRAL FORM

Community Outreach in Pediatrics/Psychiatry and Education Program

School Support Services

Student Name: Joe Blow
School: School #1
D.O.B.: 1/1/80
School Phone: 888-2345
Parent(s)/Legal Guardian: Joe Blow Sr.
Jenny Blow
School Contact: Jane Doe
CLC Specialist:
Address: #2, 2222 - 22nd St. N.W.
CBE Authorization Signed: ☑ Yes ☐ No
Postal Code: T1A 2R3
COPE Consent Form (G014): ☑ Yes ☐ No
Home Phone: 888-1111 Work Phone: 888-8888
Grade: 1
Student's Alberta Health Care Number:
Name of Family Physician and/or Pediatrician: Dr. Uni Number
Phone Number of Doctor(s): 888-1234

Is the student in question:	Please rate the concern by circling a number on the scale 1-5: 1 represents "No concern" and 5 represents "High concern."				
Disruptive in the classroom?	1	2	3	4	[✓ 5]
Underachieving academically?	1	2	3	4	[✓ 5]
Physically aggressive or violent?	1	2	3	4	[✓ 5]
Socially inappropriate with peers?	1	2	[✓ 3]	4	5
Emotionally restricted?	1	2	3	4	[✓ 5]
Appear sad?	1	2	3	4	[✓ 5]
Appear to have low self-esteem?	1	2	3	4	[✓ 5]
Often out of seat, fidgets or squirms?	1	2	3	[✓ 4]	5
Inattentive, distracted/distractible?	1	2	3	4	[✓ 5]
Uncoordinated in fine-motor skills?	1	2	3	4	[✓ 5]
Uncoordinated in gross-motor skills?	1	2	3	4	[✓ 5]
Impaired in hearing?	1	2	3	4	[✓ 5]
Impaired in vision?	1	2	3	4	[✓ 5]
Fearful?	1	2	3	4	[✓ 5]
Avoidant?	1	2	3	4	[✓ 5]
Clingy?	1	2	3	4	[✓ 5]
Odd, bizarre or peculiar behaviour?	1	2	3	4	[✓ 5]
Stealing?	[✓ 1]	2	3	4	5
Bullying?	1	2	3	4	[✓ 5]
Displaying non-compliant behaviour?	1	2	3	4	[✓ 5]
Appear neglected?	1	2	3	4	[✓ 5]
Appear abused?	1	2	3	4	[✓ 5]
Appear under stress?	1	2	3	4	[✓ 5]
Suicidal or self-harming?	1	2	3	4	[✓ 5]
Delayed in understanding or using language?	1	2	3	4	[✓ 5]
Appears to have health concerns: nutrition, allergies, circles under eyes, etc. Please Specify.	1	2	3	4	5
Other? Please specify:					

Additional Presenting Concerns:

Appears confused

Family Background/Genogram:

What questions are you hoping to get answered?

Doctors Screening Recommendations:

Authorization

The personal information on this form is collected in accordance with provisions as stipulated with the School Act, and under the authority of Section 32(c) of Alberta's Freedom of Information and Protection Act for the COPE Program. If you have any questions about this consent form, please contact the COPE Program at Parkdale Centre, 728 – 32nd Street NW, T2N 2V9. Phone: 777-7240, ext. 2239; Fax 777-8103.

November 12, 1999

Illustration of Monthly Calendar

MONTHLY CALENDAR

JANUARY, 2000

MONDAY	MONDAY	TUESDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1 *Physician A* *10:00- BLOW, J.*	1 *Physician B* *8:00- DOE, J.* *10:00- JOHNSON*	2 *Physician C* *9:30- CHAN, C.* *11:00- JACKSON, M.* *Physician J* *8:00 – SIMPSON, O.* *10:00- JONES, J.*	2 *Physician K* *9:30- DOE, J.* *11:00- DANIELS, J.*	3 *Physician F* *8:30 – Noon* *Initial Consultations*	4 *Physician E* *9:00- WALKER, J.* *11:00- STARR, R.* *Physician F* *8:30- QUE, S.* *10:30- SUE, P.*	5 *Physician G* *9:00- HORTON, T.* *10:30- JONES, J.* *Physician H.* *9:30- HOPE, B.* *11:00- MURRAY, A.*
8 *Physician A* *9:00-* *10:30-* *Physician J* *9:00-* *10:30-*	8 *Physician B* *8:00-* *10:00-*	9 *Physician C* *9:30-* *11:00-* *Physician J* *8:00-* *10:00-*	9 *Physician D* *1:00-* *3:00-*	10	11 *Physician F* *8:30-* *10:30-*	12 *Physician L* *8:00-* *10:00-*
15 *Physician A* *9:00-* *10:30-* *Physician J* *9:00-* *10:30-*	15 *Physician B* *8:00-* *10:00-*	16 *Physician C* *9:30-* *11:00-* *Physician J* *8:00-* *10:00-*	16 *Physician K* *9:30-* *11:00-*	17	18 *Physician E* *9:00-* *11:00-* *Physician F* *8:30-* *10:30-*	19 *Physician G* *9:00-* *10:30-* *Physician H* *9:30-* *11:00-*
22 *Physician A* *10:00-* *Physician J* *9:00-* *10:30-*	22 *Physician B* *8:00-* *10:00-*	23 *Physician C* *9:30-* *11:00-* *Physician J* *8:00-* *10:00-*	23 *Physician K & L* *1:00-* *3:30-*	24 *Physician F* *8:30-* *10:30-*	25 *Physician F* *8:30-* *10:30-*	26 *Physician L* *8:00-* *10:00-*

Etc….

Illustration of Monthly Tracking Community Physician Forms

WEEKLY APPOINTMENTS

	DOCTOR **CLC**	**CASE**	**GP REFERRAL FORM**
DAY OF THE WEEK ***DATE***	***Physician Name @ Location*** ***10:00am-Noon***	***Name of Student (Name of School)***	***Date received Family Physician Referral***
MONDAY January 1, 2000	***Physician A*** *@ School # 8* *10:00am-Noon*	*BLOW, Joe (School #4)*	*December 17, 1999*
	Physician B *@ School # 7* *8:00-10:00am*	*DOE, Jane (School #1)*	*December 21, 1999*
	10:00am-Noon	*JOHNSON, Jedd (School #2)*	*January 20, 1999*
TUESDAY January 2, 2000	***Physician C*** *@ School # 8* *9:30-11:00am*	*CHAN, Chester (School #5)*	*Referral not received yet*
	11:00am-12:30pm	*JACKSON, Michael (School #6)*	*November 12, 1999*
	Physician J *@ School #9* *8:00-10:00am*	*SIMPSON, O.J. (School #4)*	*February 14, 1999*
	10:00am-Noon	*JONES, Jenny (School #4)*	*February 21, 1999*
	Physician K *@ School # 11* *9:30-11:00am*	*DOE, John (School #15)*	*March 5, 1999*

	DOCTOR **CLC**	**CASE**	**GP REFERRAL FORM**
	11:00am-12:30pm	*DANIELS, Jack* *(School #16)*	*April 4, 1999*
WEDNESDAY January 3, 2000	***Physician F*** *@ School # 8* *INITIAL CONSULTATIONS* *8:30-9:00am*	*DEER, John* *(School # 4)*	*Not Yet*
	9:00-9:30am	*SUNG, Alfred* *(School # 4)*	*Not Yet*
	9:30-10:00am	*CANDY, John* *(School # 4)*	*Not Yet*
	10:00-10:30am	*SMITH, William* *(School # 4)*	*Not Yet*
	10:30-11:00am	*RYDER, Winnona* *(School # 5)*	*Not Yet*
	11:00-11:30am	*GARBO, Gretta* *(School # 5)*	*Not Yet*
	11:30am-Noon	*MELLANCAMP, John* *(School # 5)*	*Not Yet*
THURSDAY January 4, 2000	***Physician E*** *@ School # 11* *9:00-11:00am*	*WALKER, Johnny* *(School #17)*	*December 31, 1999*

FRIDAY January 5, 2000	*11:00am-1:00pm*	*STARR, Ringo (School #15)*	*November 30, 1998*
	Physician F *@ School # 8* *8:30-10:30am*	*QUE, Susie (School #4)*	*May 5, 1999*
	10:30am-12:30pm	*SUE, Peggy (School #5)*	*June 6, 1999*
	Physician G *@ School # 10* *9:00-10:30am*	*HORTON, Timothy (School #12)*	*August 9, 1999*
	10:30am-Noon	*JONES, John (School #13)*	*July 1, 1999*
	Physician H *@ School # 11* *9:30-11:00am*	*HOPE, Bob (School #17)*	*January 1, 2000*
	11:00am-12:30pm	*MURRAY, Anne (School # 15)*	*June 2, 1999*

Detailed Scheduled of a Week's Appointments

DAILY APPOINTMENT CALENDAR

Time		(Date) (Physician) @ (Location) (hours physician is working)	*MONDAY* *January 1, 2000* *Physician A* *@ School # 8* *(10:00am – Noon)*	*MONDAY* *January 1, 2000* *Physician B* *@ School # 7* *(8:00-Noon)*	*TUESDAY* *January 2, 2000* *Physician C* *@ School # 8* *(9:30am-12:30pm)*
8 A.M.	00	**Name of student**		*DOE, Jane*	
	15	**(School student attends)**		*(School # 1)*	
	30			↓	
	45			↓	
9 A.M.	00			↓	
	15			↓	
	30			↓	*CHAN, Chester*
	45			↓	*(School # 5)*
10 A.M.	00		*BLOW, Joe*	*JOHNSON, Jedd*	↓
	15		*(School # 4)*	*(School # 2)*	↓
	30		↓	↓	↓
	45		↓	↓	↓
11 A.M.	00		↓	↓	*JACKSON, Michael*
	15		↓	↓	*(School # 6)*
	30		↓	↓	↓
	45		↓	↓	↓
12 P.M.	00				↓
	15				↓
	30				
	45				
1 P.M.	00				
	15				
	30				
	45				
2 P.M.	00				
	15				
	30				
	45				
3 P.M.	00				
	15				
	30				
	45				
4 P.M.	00				
	15				
	30				
	45				

Time		TUESDAY January 2, 2000 Physician J @ School # 9 (8:00am-Noon)	TUESDAY January 2, 2000 Physician K @ School # 11 (9:30am-12:30pm)	WEDNESDAY January 3, 2000 Physician F @ School # 8 (8:30am-Noon) Initial Consultations	THURSDAY January 4, 2000 Physician E @ School # 11 (9:00am-1:00pm)
8 A.M.	**00**	*SIMPSON, O.J.*			
	15	*(School # 4)*			
	30			*DEER, John*	
	45			*(School #4)*	
9 A.M.	**00**			*SUNG, Alfred*	*WALKER, Johnny*
	15			*(School #4)*	*(School #17)*
	30		*DOE, John*	*CANDY, John*	
	45	↓	*(School # 15)*	*(School #4)*	
10 A.M.	**00**	*JONES, Jenny*		*SMITH, William*	
	15	*(School # 4)*		*(School #4)*	
	30			*RYDER, Winnona*	
	45		↓	*(School #5)*	↓
11 A.M.	**00**		*DANIELS, Jack*	*GARBO, Gretta*	*STARR, Ringo*
	15		*(School # 16)*	*(School #5)*	*(School #15)*
	30			*MELLANCAMP, John*	
	45	↓		*(School #5)*	
12 P.M.	**00**				
	15		↓		
	30				
	45				↓
1 P.M.	**00**				
	15				
	30				
	45				
2 P.M.	**00**				
	15				
	30				
	45				
3 P.M.	**00**				
	15				
	30				
	45				
4 P.M.	**00**				
	15				
	30				
	45				

Time		THURSDAY January 4, 2000 Physician F @ School # 8 (8:30am-12:30pm)	FRIDAY January 5, 2000 Physician G @ School # 10 (9:00am-Noon)	FRIDAY January 5, 2000 Physician H @ School # 11 (9:30am-12:30pm)	
8	00				
A.M.	15				
	30	QUE, Susie			
	45	(School #4)			
9	00	↓	HORTON, Timothy		
A.M.	15	↓	(School #12)		
	30	↓	↓	HOPE, Bob	
	45	↓	↓	(School #17)	
10	00	↓	↓	↓	
A.M.	15	↓	↓	↓	
	30	SUE, Peggy	JONES, John	↓	
	45	(School #5)	(School #13)	↓	
11	00	↓	↓	MURRAY, Anne	
A.M.	15	↓	↓	(School #15)	
	30	↓	↓	↓	
	45	↓	↓	↓	
12	00	↓		↓	
P.M.	15	↓		↓	
	30				
	45				
1	00				
P.M.	15				
	30				
	45				
2	00				
P.M.	15				
	30				
	45				
3	00				
P.M.	15				
	30				
	45				
4	00				
P.M.	15				
	30				
	45				

Faxes Sent out Weekly to all Parties

Parkdale Centre
728 - 32 St. N.W.
Calgary, Alberta
T2N 2V9
Phone: 777-7240, ext. 2239
Fax: 777-8103
E-mail: tklowe@cbe.ab.ca

C.O.P.E.

Fax

To:	Dr. A.	**From:**	COPE Staff Member Name
Fax:	###-####	**Date:**	November 24, 1999
Phone:	###-####	**Pages:**	1
Re:	Next Week's COPE Appointments	**CC:**	

☐ **Urgent** ✓ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Comments:

Please find listed below your appointments for the week of **NOVEMBER 29 – DECEMBER 3, 1999:** as well as any relevant details about the appointment for your information.

Also, please find attached a list of all demographic information on each of the patients to be seen which you may find useful.

APPT. DATE: NOVEMBER 29, 1999:

TIME	PATIENT NAME	LOCATION
8:30-10:30am	BLOW, Joe	School #5
10:30am-12:30pm	DOE, Jane	School #5

Parkdale Centre
728 - 32 St. N.W.
Calgary, Alberta
T2N 2V9
Phone: 777-7240, ext. 2239
Fax: 777-8103

C.O.P.E.

Fax

To:	CLC Specialist Name	**From:**	COPE Staff Member Name
Fax:	###-####	**Date:**	November 24, 1999
Phone:	###-####	**Pages:**	1
Re:	Next Week COPE Doctor's Appointments	**CC:**	

☐ **Urgent** ✓ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

•Comments:

Please find attached a list of appointments for your CLC

For the week of : **NOVEMBER 29 – DECEMBER 3, 1999 :**

NOVEMBER 29, 1999:

STUDENT NAME	**Home School**	**Appt. Time**	**Location**	**Consulting Dr.**
BLOW, Joe	School #1	8:30am	School #5	Dr. A.
DOE, Jane	School #2	10:30am	School #5	Dr. B.

Parkdale Centre
728 - 32 St. N.W.
Calgary, Alberta
T2N 2V9
Phone: 777-7240, ext. 2239
Fax: 777-8103
E-mail: tklowe@cbe.ab.ca

C.O.P.E.

Fax

To: COPE Contact Person Name – School #5 **From:** COPE Staff Member Name

Fax: ###-#### **Date:** November 24, 1999

Phone: ###-#### **Pages:** 1

Re: Next Week's COPE Doctors Appointments **CC:**

☐ **Urgent** ✓ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

•Comments:

Please find listed below the COPE Doctor's Appointments to be held at your school next week.

For the week of **NOVEMBER 29 – DECEMBER 3, 1999:**

NOVEMBER 29, 1999:

TIME	**STUDENT NAME**	**FROM**	**Consulting Dr.**
8:30-10:30am	BLOW, Joe	School #1	Dr. A.
10:30am – 12:30pm	DOE, Jane	School #2	Dr. A.

Parkdale Centre
728 - 32 St. N.W.
Calgary, Alberta
T2N 2V9
Phone: 777-7240, ext. 2239
Fax: 777-8103
E-mail: tklowe@cbe.ab.ca

C.O.P.E.

Fax

To:	COPE Contact Person Name – School #1	**From:**	COPE Staff Member Name
Fax:	###-####	**Date:**	November 24, 1999
Phone:	###-####	**Pages:**	1
Re:	Next Week's COPE Doctors Appointments	**CC:**	

☐ **Urgent** ✓ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

•**Comments:**

Please find listed below the students from your school scheduled to have COPE Doctors appointments next week.

For the week of **NOVEMBER 29 – DECEMBER 3, 1999:**

NOVEMBER 29, 1999:

STUDENT NAME	TIME	LOCATION	Consulting Dr.
BLOW, Joe	8:30-10:30am	School #5	Dr. A.

C.O.P.E. Forms Revised Post Research

C.O.P.E.
Community Outreach in
Pediatrics/Psychiatry and Education
Parkdale Centre
728 - 32 St. N.W.
Calgary, Alberta, Canada
T2N 2V9

Phone: 777-7240, ext. 2239
Fax: 777-8103

School-Based Medical Intervention

The COPE Program is designed to serve families whose elementary school-aged children are experiencing difficulties with their learning or behavior in the school/classroom setting.

A shared concern amongst parents, educators and doctors is early identification and intervention for children experiencing difficulties in the above areas.

COPE is a collaboration between the Calgary Regional Health Authority, the Calgary Board of Education and the Department of Pediatrics at the University of Calgary. Together, they have a joint commitment to work with families to better understand these problems and develop workable solutions.

The Purpose of the Study:

To determine if school-based medical consultation is an effective, and efficient mode of service delivery.

COPE Staff:

Vandora Moxam
COPE Coordinator
777-7240, ext.2251

Dr. Margaret Clarke
COPE Director
777-7240, ext.2239

Mark Reckord
COPE Family Liaison
777-7240, ext.2222

Tanis Lowe
Office Administrator
777-7240,ext. 2239

Joanna Card
Administrative Assistant
777-7240,ext.2224

Doctors Participating in the Program:

Dr. Carla Atkinson
Dr. Susan Carpenter
Dr. Margaret Clarke
Dr. Neil Cooper
Dr. Allan Donsky
Dr. Geoff Fisher
Dr. Thiru Govender
Dr. Jean-Francois Lemay
Dr. Ted Prince
Dr. Dan Ross
Dr. Pam Veale
Dr. Tim Yates

Participation in COPE may involve students and their parents meeting with school personnel and C.O.P.E. staff for consultation regarding the student's medical, learning, and/or social and emotional needs.

We expect that providing help at an early stage to children who have learning or behavioral problems at school, will result in improved learning and better coping skills for these students.

Health Canada and Alberta Health fund the C.O.P.E. Program.

Calgary Board of Education

SE-030 (1999/05)

Calgary Board of Education

Parental Authorization

Direction: *Authorization is a signed statement of informed consent to provide special assistance for the benefit of the student. Signature must be provided by the parent/guardian if the student has not reached the age of majority. If the student is eighteen years of age or older, the student must provide consent instead of parent/guardian.*

Student Identification Information

Student's Name *(Last)* *(First)* *(Initial)*

Date of Birth ☐ ☐ ☐ Yr Mo Da

School Teacher Grade/Class

Consent (Indicate type ☐ of authorization.)

☐ I hereby consent to the provision of psychological assessment by and consultation with authorized staff employed by the Calgary Board of Education in regards to the exceptional needs of the aforenamed student.

I also acknowledge that I have been informed of the nature and intent of this assessment and I understand that school staff will subsequently review the results of this assessment with me and explain any forthcoming recommendations. It is understood that the psychologist will make the initial interpretation.

☒ I hereby consent to the release to the Calgary Board of Education, and to any duly authorized agent hereof, all the records, reports of examinations, and information of medical, psychiatric/psychological, and/or educational assessments or program rendered to the aforenamed student.

Community Outreach in Pediatrics/Psychiatry and Education (C.O.P.E.)

☒ I hereby authorize the Calgary Board of Education, and any duly authorized agent thereof, to release to:

Community Outreach in Pediatrics/Psychiatry and Education (C.O.P.E.)

Name of school, district, agency, person, etc.

all school records, report assessments, and information of medical, psychiatric, psychological, and/or educational assessments or program rendered to the aforenamed student.

Authorization Signatures

This consent and authorization will be in effect for the current school year.

Name of Consenting Person

Name and Role of School Official

Signature of Consenting Person

Signature of School Official

Date

Date

Please Return To:

Role of School Official Telephone Number

☐ ☐ ☐ Yr Mo Da

Address

G014(11/99)

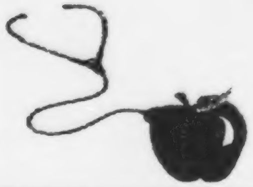
Calgary Board of Education

COPE CONSENT FORM

Community Outreach in Pediatrics/Psychiatry and Education Program

School Support Services

Parkdale Centre
728 – 32 Street NW, Calgary AB T2N 2V9
Phone: 777-7240, ext. 2239; Fax: 777-8103



Margaret E. Clarke, MD, FRCPC
COPE, Program Director

Sponsor: Alberta Health

By signing this consent form, you consent for you and your child to participate in the COPE Program.

Student Identification Information

Student's Name (Last) ____________ *(First)* ____________ *(Initial)* ____________

Date of Birth ______/______/______ *Year* *Month* *Day*

School ____________ *Teacher* ____________ *Grade/Class* ____________

The COPE Program is designed to serve families whose elementary school-aged children are experiencing difficulties with their learning or behaviour in the school setting.

COPE is a collaboration between the Calgary Regional Health Authority, the Calgary Board of Education and the Department of Pediatrics at the University of Calgary. Together, they have a joint commitment to work with families to better understand these problems and develop workable solutions.

Participation in the COPE Program may involve you and your child meeting with school personnel and COPE staff for consultation regarding your child's medical, learning, social and/or emotional needs.

If you or your child suffer any injury as a result of being in this program, no financial compensation will be provided to you by Alberta Health, the University of Calgary, the Calgary Regional Health Authority, the Calgary Board of Education or program staff. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

To show that you have read the information above, and that you agree to be involved in the project, please check each of the boxes below that apply, and sign the consent form.

☐ I request that my child (named above) be referred to the COPE program for pediatric and/or child psychiatry consultation.

☐ I acknowledge that I have been informed of the nature and intent of this assessment and I understand that the medical or COPE staff involved with this program will review the results of this assessment with me and a school representative, and explain any recommendations.

☐ I provide consent for my child's doctor to disclose the information requested on the physician form to the medical and COPE staff involved with this program.

☐ I provide consent for the Calgary Board of Education, and any duly authorized agent thereof, to release to the COPE program school records, assessment reports and information of medical, psychiatric, psychological and/or educational assessments or program rendered to my child.

☐ I consent to be contacted by a COPE representative to provide feedback on my family's involvement with the COPE Program.

NOTE: Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in this Program. Your signature also indicates that you have the proper legal authority to provide this consent.

If you have further questions concerning matters related to this program, please contact: COPE Program, 777-7240, extension 2239.

Authorization Signatures

Name of Legal Guardian (please print)	*Name and Role of Witness (please print)*
Signature of Legal Guardian	*Signature of Witness*
Date	*Date*

Authorization

The personal information on this form is collected in accordance with provisions as stipulated with the School Act, and under the authority of Section 32(c) of Alberta's Freedom of Information and Protection Act for the COPE Program. If you have any questions about this consent form, please contact the COPE Program at Parkdale Centre, 728 – 32nd Street NW, T2N 2V9. Phone: 777-7240, ext. 2239; Fax 777-8103.

November 12, 1999

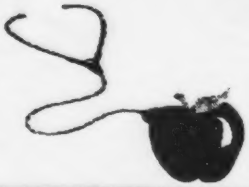
G013(11/99)

Calgary Board of Education

COPE REFERRAL FORM

Community Outreach in Pediatrics/Psychiatry and Education Program

School Support Services



Student Name: ____________________

D.O.B.: ____________________

arent(s)/Legal Guardian: ____________________

Address: ____________________

Postal Code: ____________________

Home Phone: __________ Work Phone: __________

School: ____________________

School Phone: ____________________

School Contact: ____________________

CLC Specialist: __________

CBE Authorization Signed: ☐ Yes ☐ No

COPE Consent Form (G014): ☐ Yes ☐ No

Grade: __________

Student's Alberta Health Care Number: ____________________

Name of Family Physician and/or Pediatrician: ____________________

Phone Number of Doctor(s): ____________________

s the student in question:	**Please rate the concern by circling a number on the scale 1–5: 1 represents "No concern" and 5 represents "High concern."**				
Disruptive in the classroom?	1	2	3	4	5
Underachieving academically?	1	2	3	4	5
Physically aggressive or violent?	1	2	3	4	5
Socially inappropriate with peers?	1	2	3	4	5
Emotionally restricted?	1	2	3	4	5
Appear sad?	1	2	3	4	5
Appear to have low self-esteem?	1	2	3	4	5
Often out of seat, fidgets or squirms?	1	2	3	4	5
Inattentive, distracted/distractible?	1	2	3	4	5
Uncoordinated in fine-motor skills?	1	2	3	4	5
Uncoordinated in gross-motor skills?	1	2	3	4	5
Impaired in hearing?	1	2	3	4	5
Impaired in vision?	1	2	3	4	5
Fearful?	1	2	3	4	5
Avoidant?	1	2	3	4	5
Clingy?	1	2	3	4	5
Odd, bizarre or peculiar behaviour?	1	2	3	4	5
Stealing?	1	2	3	4	5
Bullying?	1	2	3	4	5
Displaying non-compliant behaviour?	1	2	3	4	5
Appear neglected?	1	2	3	4	5
Appear abused?	1	2	3	4	5
Appear under stress?	1	2	3	4	5
Suicidal or self-harming?	1	2	3	4	5
Delayed in understanding or using language?	1	2	3	4	5
Appears to have health concerns: nutrition, allergies, circles under eyes, etc. Please Specify.	1	2	3	4	5
Other? Please specify:					

____

____

COPE REFERRAL FORM – Page 2

Additional Presenting Concerns:

Family Background/Genogram:

What questions are you hoping to get answered?

Doctors Screening Recommendations:

Authorization

The personal information on this form is collected in accordance with provisions as stipulated with the School Act, and under the authority of Section 32(c) of Alberta's Freedom of Information and Protection Act for the COPE Program. If you have any questions about this consent form, please contact the COPE Program at Parkdale Centre, 728 – 32nd Street NW, T2N 2V9. Phone: 777-7240, ext. 2239; Fax 777-8103.

November 12, 1999

A-74

COPE
Community Outreach in Pediatrics/Psychiatry and Education Program
Parkdale Centre
728 – 32 Street NW, Calgary AB T2N 2V9
Phone: 777-7240, ext. 2230; Fax: 777-8103

Dear ____________________________,

Your child, ____________________, has been identified by school staff as having some learning or behavioural concerns, and directed to the COPE program (Community Outreach in Pediatrics, Psychiatry, and Education). In this partnership initiative between the Calgary Regional Health Authority and the Calgary Board of Education, students and their families have the opportunity to meet with medical doctors experienced in behavioural and learning difficulties in school-aged children.

The intended outcome of this consultation process is:

- An assessment of the student's situation and management recommendations for the school, family and primary medical care provider.

COPE is not resourced to provide ongoing follow-up to the child. This task is assigned to the school, family, and the primary medical care provider who is your family doctor or pediatrician.

It is essential that your child have some attachment to a community family doctor or pediatrician. We would ask you to make an appointment with your doctor, with your child present, to discuss the concerns that the school staff have reviewed with you. At that time please give your doctor the enclosed information and referral sheet and ask him or her if they agree with the COPE process and if they would be willing to provide us with some information. *Please* clarify the nature of the appointment to the doctor's office staff: "to discuss learning or behavioural difficulties", most physicians would set aside a longer appointment for a consultation of this nature.

If you do not have a family doctor, names of doctors accepting new patients are available at the CRHA Info Line at 265-INFO (4636).

If you have any difficulties, if you need clarification about why we think it is important to have involvement with a community doctor before meeting with our specialized doctors, or for any other questions, please call the program Coordinator, Vandora Moxam at 777-7240 ext. 2251.

Sincerely,

Margaret E Clarke

Dr. Margaret E. Clarke, MD FRCP(C)
COPE, Program Director

G015 (11/99)

Physician Referral Form – COPE

Community Outreach in Pediatrics/Psychiatry and Education Program

Please complete the following information when requesting assessment and consultation services for children and families with learning, behavioural and emotional challenges who have consented to participate in the COPE project.

Patient Demographics – Please stamp information

- What questions would you like answered as part of this referral?
- What type of service is the family looking for at this time, and what have they accomplished?
- Are all family members willing to be involved in this assessment? ☐ Yes ☐ No

AREAS OF CONCERN: Please indicate any and all areas of concern.

☐ Physical/Mental Health
☐ Family Issues
☐ Peer Relationships
☐ Separation/Custody
☐ Speech–Language
☐ Fine/Gross Motor
☐ Hearing/Vision
☐ Odd/Unusual Behaviour
☐ Academic Performance
☐ Attention/Over-Activity
☐ Social Behaviour Problems
☐ Aggression to People/Animals
☐ Negative/Hostile/Defiant Behaviours
☐ Destructive to Property
☐ Theft
☐ Lying
☐ Losses/Depression/Withdrawal
☐ Anxiety/Traumatic Events
☐ Hallucinations/Traumatic Events
☐ Eating Disorder/Body Image Concerns
☐ Substance Abuse
☐ Sexual Abuse/Sexually Inappropriate
☐ Physical Abuse
☐ Neglect
☐ Emotional Abuse
☐ Domestic Abuse

SEVERITY/URGENCY:

☐ Situation not urgent
☐ Situation requires attention within one month
☐ Child is a danger to self and/or others/unpredictable

MEDICATIONS/ALLERGIES:

OTHER ASSESSMENTS COMPLETED:
Please indicate reports if available

☐ Speech Therapy
☐ Occupational Therapy
☐ Community Health Nurse
☐ Pediatrics
☐ Social Services (income support)
☐ Other
☐ Physiotherapy
☐ Education
☐ Home Care
☐ Psychiatry
☐ Child Welfare

RELEVANT MEDICAL PROGRAMS – LIST

OTHER AGENCIES CURRENTLY INVOLVED WITH FAMILY – DOES FAMILY FIND INVOLVEMENT HELPFUL?

OTHER RELEVANT INFORMATION YOU WOULD LIKE TO ADD:

Name of child's regular physician: ______________________

Address: ______________________ Postal Code: ____________

Practitioner ULI#: ____________ Phone #: ____________ Fax #: ____________

Physician Signature: ______________________ Date: ____________

Authorization

The personal information on this form is being collected in order to do a medical assessment regarding school learning difficulties, under authority of Section 32 c of the Alberta Freedom of Information and Protection of Privacy Act. If you have any questions about the program to which this child is being referred, please contact: The COPE Program, Phone 777-7240, extension 2239.

Thank you. Please fax this form to the COPE Program at 777-8103.

COPE
Community Outreach in Pediatrics/Psychiatry and Education Program
Parkdale Centre
728 – 32 Street NW, Calgary AB T2N 2V9
Phone: 777-7240, ext. 2239; Fax: 777-8103

REFERRAL PROCESS

School identifies student with learning, behavioral, emotional difficulties

⇩

Case presented at school's SRG meeting

Using COPE Referral form ☜

At SRG, case is determined to be appropriate for a C.O.P.E. Consultation

⇩

CBE Authorization Form ☜

C.O.P.E. Consent Form ☜

Physician Form

With the family being in agreement the CLC Specialist/School personnel gets CBE Parental Authorization and C.O.P.E. Consent form signed for discussion with C.O.P.E. and gives the parent the Physician Form for the family doctor to fill out.

⇩

School personnel presents case to C.O.P.E. team at an initial consultation meeting. The C.O.P.E. Team, along with the school makes recommendations on how to proceed with case.
For Example:

Doctors see student

Or

Family Liaison involvement

Or

Referral to a community resource

Or

Or a combination of the above

⇩

Follow-up if required

COPE
Community Outreach in Pediatrics/Psychiatry and Education Program
Parkdale Centre
728 – 32 Street NW, Calgary AB T2N 2V9
Phone: 777-7240, ext. 2239; Fax: 777-8103

A TYPICAL C.O.P.E. PROFILE

Based on referrals from the last year and in consultation with physicians and educators in the elementary schools, the following points profile a potential C.O.P.E. candidate.

Lack of resources or ability to access resources in these areas:

- Positive parental input
- Disruptive in the classroom
- Underachieving academically
- Physically aggressive or violent
- Socially inappropriate with peers
- Emotionally restricted or sad, has low self-esteem
- Often out of seat, fidgety or squirmy
- Inattentive, distracted/distractible
- Uncoordinated in fine or gross motor skills
- Impaired in hearing of vision
- Fearful, avoidant or clingy
- Odd, bizarre or peculiar in behavior
- Inappropriate sexual behavior or speech
- Stealing, bullying or non-compliant
- Suicidal or self-harming
- Apparently neglected, abused or appears to be under stress
- Delayed in understanding or using language
- Appears to have health concerns; nutrition, allergies, circles under eyes, etc.

C.O.P.E./school working relationship with students will be an essential component to the success of this initiative

18-Jan-00

G012(11/99)

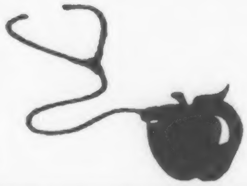
Calgary Board of Education

COPE CONSULTATION FORM

Community Outreach in Pediatrics/Psychiatry and Education Program

School Support Services

Parkdale Centre
728 – 32 Street NW, Calgary AB T2N 2V9
Phone: 777-7240, ext. 2239; Fax: 777-8103



Date: ______________ Student ID#: ______________________ School: ____

Present: ____

____ Form Completed By: _______________________

Student Name: ______________________________ Grade: ___________ D.O.B.: ____________________

Phone: ___________________________________ Alberta Health Care #: ______________________

Address: ____

Recommendations from Consultation (Action Plan): **Facilitator**

I, being the parent/legal guardian with the proper legal authority, have read the information contained on this form and do hereby consent on behalf of my child/ward to the use and disclosure (including a copy on my child's/ward's student record) of the personal information collected for the purpose of having all parties informed of recommendations and actions made at this COPE consultation.

_________________________ _________________________ _________________________

Name (please print) *Signature* *Date*

Authorization

The personal information on this form is collected in accordance with provisions as stipulated with the School Act, and under the authority of Section 32(c) of Albeta's Freedom of Information and Protection Act for the COPE (Community Outreach in Pediatrics/Psychiatry and Education) Program. If you have any questions about this consent form, please contact the COPE Program at Parkdale Centre, 728 – 32nd Street NW, T2N 2V9. Phone: 777-7240, ext. 2239; Fax 777-8103.

cc: COPE Program (White copy), School (Pink Copy), Parent (Yellow Copy), COPE Doctor (Goldenrod Copy)

A-79

C.O.P.E. Consultation Form

G012(11/99)

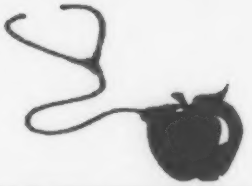
Calgary Board of Education

COPE CONSULTATION FORM

Community Outreach in Pediatrics/Psychiatry and Education Program

School Support Services

Parkdale Centre
728 – 32 Street NW, Calgary AB T2N 2V9
Phone: 777-7240, ext. 2239; Fax: 777-8103



Date: ______________ Student ID#: ______________________ School: ______________________________

Present: ____

____ Form Completed By: ______________________

Student Name: ________________________________ Grade: __________ D.O.B.: ________________

Phone: ______________________________________ Alberta Health Care #: ______________________

Address: ____

Recommendations from Consultation (Action Plan): **Facilitator**

I, being the parent/legal guardian with the proper legal authority, have read the information contained on this form and do hereby consent on behalf of my child/ward to the use and disclosure (including a copy on my child's/ward's student record) of the personal information collected for the purpose of having all parties informed of recommendations and actions made at this COPE consultation.

Name (please print) ____________ *Signature* ____________ *Date* ____________

Authorization

The personal information on this form is collected in accordance with provisions as stipulated with the School Act, and under the authority of Section 32(c) of Alberta's Freedom of Information and Protection Act for the COPE (Community Outreach in Pediatrics/Psychiatry and Education) Program. If you have any questions about this consent form, please contact the COPE Program at Parkdale Centre, 728 – 32nd Street NW, T2N 2V9. Phone: 777-7240, ext. 2239; Fax 777-8103.

cc: COPE Program (White copy), School (Pink Copy), Parent (Yellow Copy), COPE Doctor (Goldenrod Copy)

A-80

Appendix B Parent / Child Surveys

Contents:

1. Parent Survey Initial B-1
2. Parent Survey 4-month B-21
3. Parent Survey 8-month B-35
4. Child Survey Initial B-53
5. Child Survey 4-month B-66
6. Child Survey 8-month B-77

PARENT SURVEY #1 - INTERVIEWER'S COPY

The questions asked in this interview are intended to measure a wide range of experiences and behaviors of your child. Most of these questions were asked in a national Survey of Children in Canada. We will use the answers to try to understand better the situation of children with Emotional, Behavioral or Learning problems.

There are no right and wrong answers for these questions. We want to know about your child. Please answer the questions as accurately as possible.

The interview consists of 6 sections. They are:

- use of health professionals
- school experience
- behavior
- parenting
- and background characteristics

Let me begin by asking a few questions about yourself and your child:

Personal Information

1. Your name:

2. Child's name:

3. Your relationship to child:

4. If you had to describe in your own words the problems your child has, how would you describe them?

5. If you had to describe in your own words the gifts or strengths that you child has, how would you describe them?

6. In question 4, you describe the problems your child experiences.

   a. when did this behavior become a problem at his/her school?

   b. how would you describe the school's response to your child's problem?

   c. How satisfied are you with the response your child has gotten from the school to date?

      1. very satisfied
      2. somewhat satisfied
      3. not very satisfied
      4. not at all satisfied

   d. Is there something that the school and/or other professionals should be doing for your child that they are not doing? Please elaborate.

7. Please describe the ways (if any) in which you have been involved in identifying emotional, behavioral and/or learning problems with your child, and in developing a response along with the school.

8. How have decisions about your child's emotional, behavioral or learning problems at school been communicated to you?

9. What types of services are you aware of in Calgary that are available to families who have children with emotional, behavioral and/or learning problems?

10. Which of these services have you or your family used?

11. Please comment on whether you have found these services readily available, or whether there is anything that has prevented you from using them.

USE OF HEALTH PROFESSIONALS

1. In the past year, how many times have you seen or talked on the telephone with any of the following about ________'s physical, emotional or mental health? (Exclude at time of birth for babies)

a) A general practitioner, family physician?
(Enter 0 if none)

b) A pediatrician?

c) Another medical doctor (such as an orthopedist, or eye specialist)?

d) A public health nurse or nurse practitioner?

e) A dentist or orthodontist?

f) A psychiatrist or psychologist?

g) Child welfare worker or children's aid worker?

h) Any other person trained to provide treatment or counsel, for example a speech therapist, a social worker?

i) In the past 12 months, was __________ ever an overnight patient in a hospital?

YES
NO

j) If so, for what reason?

1. Respiratory illness or disease
2. Gastrointestinal illness or disease
3. Injuries
4. Other

k) Does he/she take any of the following prescribed medication on a regular basis:

1. Ventolin, inhalers or puffers for asthma?
2. Ritalin?
3. Tranquilizers or nerve pills?
4. Anti-convulsants or anti-epilieptic pills?
5. Other?

l) Has __________ ever experienced any event or situation that has caused her/him a great amount of worry or unhappiness?

m) What was this?

1. Death of parents
2. Death in family (other than parents)
3. Divorce/separation of parents
4. Move
5. Stay in hospital
6. Stay in foster home
7. Other separation from parents
8. Illness/injury of a child
9. Illness/injury of a family member
10. Abuse/fear of abuse
11. Change in household members
12. Alcoholism or mental health disorder in family
13. Conflict between parents
14. Other

SCHOOL EXPERIENCE

1. Based on your knowledge of his/her schoolwork, including her/his report cards, how is your child doing in the following areas at school this year?

1 VERY WELL	2 WELL	3 AVERAGE	4 POORLY	5 VERY POORLY

a) Reading and Other Language Arts?

b) Mathematics?

c) Written work such as composition?

d) Science?

2. How is she/he doing overall?

If under age 11, skip ahead to question #6

3. How often is _______ assigned homework?

4. On days when he/she is assigned homework, how much time does she/he usually spend doing homework?

______ Hours
______ Minutes

5. How often do you check her/his homework or provide help with homework?

1 Never Or Rarely	2 Less Than Once A Month	3 Once A Month	4 A Few Times A Month	5 Once A Week	6 A Few Times A Week	7 Daily

6. Since ____________ started school in the fall, has he/she received any help or tutoring outside of school?

1. YES
2. NO

If so, how often?

1. Once a Week 2. Twice a Week 3. More than Twice a Week

7. Does ____________ receive special/resource help because of a physical, emotional, behavioral, or some other problem that limits the kind or amount of schoolwork he/she can do?

   1. YES
   2. NO

   If yes, since ____________ started in the fall, how many times have you been contacted by her/his school regarding his/her behavior at school?

   1. None/Once
   2. Twice/Three Times
   3. Four or More Times

8. With regard to how he/she feels about school, how often does she/he look forward to going to school?

1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always

9. How important is it to you that ___________ has good grades in school?

   1. Very important
   2. Important
   3. Somewhat important
   4. Not important at all

10. How far do you hope ____________ will go in school?

    1. Primary/elementary
    2. Secondary or high school
    3. Community college or nursing school
    4. Trade, technical or vocational school, or business college
    5. University
    6. Other

11. The following are possible descriptions of his/her present school.

For each, please indicate whether you:

1 Strongly Agree	2 Agree	3 Disagree	4 Strongly Disagree	5 Not Applicable

1. Academic progress is very important at this school.
2. Most children in this school enjoy being there.
3. Parents are made to feel welcome in this school.
4. School spirit is very high.

12. During this school year, have you done any of the following? (YES = 1, NO = 2)

1. Spoken to, visited or corresponded with child's teacher?
2. Visited child's class?
3. Attended a school event in which child participated, for example, a play, sports competition or science fair?
4. Volunteered in child's class or helped with a class trip?
5. Helped elsewhere in the school, such as in the library or computer room?
6. Attended a parent-school association, home and school liason meeting, parent advisory committee or parent council meeting?
7. Fundraising?
8. Other activities?

13. How does __________ usually travel to school? (MARK ONE ONLY)

1. By school bus
2. By city bus
3. Walks/bikes
4. Is driven
5. Other

14. How long does it take him/her to get to and from school?

1. 15 minutes
2. 16 to 30 minutes
3. 31 to 45 minutes
4. 46 to 60 minutes
5. More than 60 minutes

ACTIVITIES OUTSIDE SCHOOL HOURS

In the past 12 months, outside of school hours, how often has your child taken part in each in the following activities?

Does he/she do this most, a few times a week, about once a week, about once a month or almost never?

1 Most Days	2 A Few Times A Week	3 About Once A Week	4 About Once A Month	5 Almost Never

1. Taken part in sports with a coach or instructor (except dance or gymnastics)?

2. Taken lessons or instruction in other organized physical activities with a coach or instructor such as dance, gymnastics or martial arts?

3. Taken part in unorganized sports or physical activities without coach or instructor?

4. Taken lessons or instruction in music, art or other non-sport activities?

5. Taken part in any clubs, groups or community programs with leadership, such as Beavers, Sparks, Brownies, Cubs or church groups?

6. Played computer or video games?

7. On those days, how many hours on average does she/he spend playing computer or video games?

8. About how often on average does ______________ watch T.V. or videos at home?

8. On those days, how many hours on average does he/she spend watching T.V. or videos?

9. How often does __________ read for pleasure?

10. How often does he/she play alone (e.g. riding a bike, doing a craft or hobby, playing ball)?

1 Often	2 Sometimes	3 Seldom	4 Never

BEHAVIOR

How does __________ seems to feel or act in these given situations?

Please use the answers never or not true, sometimes or somewhat true, or often or very often.

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

How often would you say that your child

1. Shows sympathy to someone who has made a mistake?
3. Can't sit still, is restless or hyperactive?
4. Destroys his/her own things?
5. Will try to help someone who has been hurt?
6. Steals at home?
7. Seems to be unhappy, sad or depressed?
8. Gets into many fights?
9. Volunteer to help clear up a mess someone else has made?
10. Is distractible, has trouble sticking to any activity?
11. When mad at someone, tries to get others to dislike that person?
12. Is not as happy as other children?
13. Destroys things belonging to her/his family, or other children?
14. If there is a quarrel or dispute, will try to stop it?
15. Fidgets?
16. Is disobedient at school?
17. Can't concentrate, can't pay attention for long?
18. Is too fearful or anxious?
19. When mad at someone, becomes friends with another to get revenge?

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

20. Is impulsive, acts without thinking?

21. Tells lies or cheats?

22. Offers to help other children (friend, brother or sister) who are having difficulty with a task?

23. Is worried?

24. Has difficulty awaiting turn in games or groups?

25. When another child accidentally hurts him/her (such as by bumping into her/him) assumes that the other child meant to do it, and then reacts with anger and fighting?

26. Tends to do things on his/her own – is rather solitary?

27. When mad at someone, says bad things behind the other's back?

28. Physically attacks people?

29. Comforts a child (friend, brother or sister) who is crying or upset?

30. Cries a lot?

31. Vandalizes?

32. Gives up easily?

33. Threatens people?

34. Spontaneously helps to pick up objects which another child has dropped (e.g., books, pencils, etc.)

35. Cannot settle to anything for more than a few moments?

36. Appears miserable, unhappy, tearful or distressed?

37. Is cruel, bullies or is mean to others?

38. Stares into space?

39. When mad at someone, says to others, "Let's not be with him/her"?

40. Is nervous, high-strung or tense?

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

41. Kicks, bites, hits other children?

42. Will invite bystanders to join in a game?

43. Steals outside the home?

44. Is attentive?

45. Has trouble enjoying him/herself?

46. Helps other children (friends, brother or sister) who are feeling sick?

47. When mad at someone, tells the other one's secrets to a third person?

48. Takes the opportunity to praise the work of less able children?

RELATIONSHIPS

Your child's relationships with friends, family and others.

1. About how many days a week does he/she do things with friends?
   1. Never
   2. 1 day a week
   3. 2-3 days a week
   4. 4-5 days a week
   5. 6-7 days a week

2. About how many close friends does she/he have?
   1. None
   2. 1
   3. 2 or 3
   4. 4 or 5
   5. 6 or more

3. When it comes to meeting new children and making new friends is he/she:
   1. Somewhat shy?
   2. About average?
   3. Very outgoing – makes friends easily?

1 Very Well	2 Quite Well	3 Pretty Well	4 Not Too Well	5 Not Well At All	6 Not Applicable
No Problems	Hardly Any Problems	Occasional Problems	Frequent Problems	Constant Problems	

4. During the past 6 months, how well has _______________ gotten along with other kids, such as friends or classmates (excluding brothers or sisters)

5. Since starting school in the fall, how well has he/she gotten along with her/his teacher(s) at school?

6. During the past 6 months, how well has he/she gotten along with his/her parent(s)?

7. During the past 6 months, how well has _______________ gotten along with her/his brother(s)/sister(s)

PARENTING

Please answer these questions about how you would react to the given situations.

1 Never	2 About Once A Week Or Less	3 A Few Times A Week	4 One Or Two Times A Day	5 Many Times Each Day

HOW OFTEN DO YOU

1. praise _______, by saying something like "Good for you!" or "What a nice thing you did" or "That's good going!"
2. and he/she talk or play wit each other, focusing attention on each other for five minutes or more, just for fun?
3. and she/he laugh together?
4. get annoyed with ________________ for saying or doing something he/she is not supposed to?
5. tell him/her that he/she is bad or not as good as others?
6. do something special with her/him that she/he enjoys?
7. play sports, hobbies or games with him/her?
8. play games with her/him?

Now we know that when parents spend time together with their children, some of the time things go well and some of the time they don't go well.

For the following questions, please express what proportion of the time things turn out in different ways.

1 Never	2 Less Than Half The Time	3 About Half The Time	4 More Than Half The Time	5 All The Time

9. Of all the times that you talk to __________ about his/her behavior, what proportion is praise?

10. Of all the times that you talk to her/him about her/his behavior, what proportion is disapproval?

11. When you give him/her a command or order to do something, what proportion of the time do you make sure that he/she does it?

12. If you tell her/him, she/he will get punished if she/he doesn't stop doing something, and she/he keeps doing it, how often will you punish her/him?

13. How often does he/she get away with things that you feel should have been punished?

14. How often do you get angry when you punish ______________?

15. How often do you think that the kind of punishment you give her/him depends on your mood?

16. How often do you feel you are having problems managing him/her in general?

17. How often is she/he able to get out of a punishment when she/he really sets her/his mind to it?

18. How often when you discipline him/her, does he/she ignore the punishment?

19. How often do you have to discipline her/him repeatedly for the same thing?

Just about all children break the rules or do things that they aren't supposed to. Also, parents react in different ways.

Please describe how often you do each of the following when your child breaks the rules or does things that he/she is not supposed to do.

1 Never	2 Rarely	3 Sometimes	4 Often	5 Always

HOW OFTEN DO YOU:

20. Tell her/him to stop?

21. Ignore it, do nothing?

22. Raise your voice, scold or yell at him/her?

23. Calmly discuss the problem?

24. Use physical punishment?

25. Describe alternative ways of behaving that are acceptable?

26. Take away privileges or put her/him in her/his room?

Please explain how often, in general in the last 6 months, you have acted in the following ways.

HOW OFTEN DO YOU:

27. smile at him/her?

28. want to know exactly where he/she is and what he/she is doing?

29. soon forget a rule that you have made?

30. praise her/him?

31. let him/her go out any evening that he/she wants?

32. tell her/him what time to be home when she/he goes out?

33. nag him/her about little things?

34. listen to his/her ideas and opinions?

35. solve a problem together when you disagree about something?

36. keep rules only when it suits you?

1 Never	2 Rarely	3 Sometimes	4 Often	5 Always

37. How often do you get angry and yell at her/him?

38. How often do you make sure that he/she knows that he/she is appreciated?

39. How often do you threaten punishment more often than you use it?

40. Hoe often do you speak of good things that she/he does?

41. How often do you find out about his/her misbehavior?

42. How often do you enforce a rule or do not enforce a rule depending on your mood?

43. How often do you hit her/him or threaten to do so?

How often do you and your child do the following things?

1 Not At All	2 A Little	3 Sometimes	4 Pretty Often	5 Almost All Or All Of The Time

HOW OFTEN DO YOU:

44. make up easily when you have a fight?

45. disagree and fight?

46. bug each other or get on each other's nerves?

47. yell at each other?

48. stay angry for a very long time when you argue?

49. refuse to talk to her/him when you disagree?

50. does he/she stomp out of the room, or house, or yard when you disagree?

51. solve the problems together when you disagree about something?

52. does another person come in to settle things or find a solution when you disagree?

1 Everyday	2 5-6 Days Per Week	3 3-4 Days Per Week	4 1-2 Days Per Week	5 1-2 Times Per Month	6 Rarely Or Never

HOW OFTEN DO YOU:

53. eat together?

54. watch T.V. together?

55. play sports together?

56. play cards or games together?

57. have a discussion together?

58. do a family project or family chores together?

59. have a family outing/entertainment together?

60. visit relatives together?

The following are about possible family situations.

61. Has he/she experienced being hungry because the family has run out of food or money to buy food?

    1. YES
    2. NO

    If so, how often?

    1. Regularly, end of the month
    2. More often than end of each month
    3. Every few months
    4. Occasionally, not a regular occurrence

    How do you cope with feeding your child when this happens?

    1. Parent/guardian skips meals or eats less
    2. Children skip meals or eat less
    3. Cut down on variety of food family usually eats
    4. Seek help from relatives
    5. Seek help from friends
    6. Seek help from social worker/government office
    7. Seek help from food bank (emergency food program)
    8. Use school meal program

9. Other

1 Often	2 Sometimes	3 Seldom	4 Never

62. How often does she/he see television shows or movies that have a lot of violence in them?

63. How often does he/she see adults or teenagers in your house physically fighting, hitting or otherwise trying to hurt others?

64. How often does she/he hang around with kids you think are frequently in trouble?

65. How many of his/her close friends do you know by sight and by first and last name?

1 All	2 Most	3 About Half	4 Only A Few	5 None

Background Characteristics

Not re-typed: as in original

Background Characteristics

This is the last part of the questionnaire, and I'd like to ask a few questions about yourself and your family's situation. The answers to these questions will be used for statistical purposes only.

1. What is the highest level of education you received (Please circle one):

    1. did not complete elementary
    2. completed elementary
    3. completed junior high
    4. completed high school
    5. some technical college
    6. completed technical college
    7. some university
    8. completed university

2. In what year were you born? ____

3. What was your total family income, before taxes, in 1998 (Please circle one)?

    1. less than $10,000
    2. $10,000 - $20,000
    3. $20,000 - $30,000
    4. $30,000 - $40,000
    5. $40,000 - $50,000
    6. $50,000 - $60,000
    7. $60,000 - $70,000
    8. $70,000 - $80,000
    9. $80,000 - $90,000
    10. more than $90,000

4. In what country were you born? ____________________

5. (If not born in Canada). In what year did you immigrate to Canada? ________

6. What language did you first learn to speak? ________________

7. What language did your child first learn to speak? ___________________

8. What language do you normally use at home? __________________

9. What is your marital status? ________________________

10. Are you: Male: ______ or Female: _____

PARENT SURVEY #2 - INTERVIEWER'S COPY

The questions asked in the first interview we did were intended to measure a wide range of experiences and behaviors of your child and were the same as those asked in a national Survey of Children in Canada. Those answers were aimed at trying to understand better the situation of children with Emotional, Behavioral or Learning problems.

This time we are looking for the same kind of information only we will be focusing on understanding your experience and your child's specific experiences over the last 4 months (i.e. since our last interview). Through this information we are trying to better understand what things are effective in helping parents, children, and teachers deal with those emotional, behavioral or learning problems.

There are no right and wrong answers for these questions. We want to know about your child. Please answer the questions as accurately as possible.

The interview consists of 6 sections. They are:

- personal information
- experiences since you were first interviewed
- use of health professionals
- school experience
- behavior
- parenting

Before we go on, do you have any comments, questions, or feedback about our last interview?

Personal Information

1. Your name:

2. Child's name:

3. Your relationship to child:

4. In our last interview, you described in your own words the problems your child was having.

   a. How would you describe your child's problems at this point?

   b. Have there been any changes in your child's emotional, behavioral, or learning problems since we last met?

   c. Describe the change:
      1. more problematic
      2. less problematic
      3. new problems

5. In our last interview, you described in your own words the gifts or strengths that your child has.

   a. How would you describe those gifts or strengths at this point?

   b. Have there been any changes in your child's strengths since we last met?

   c. Describe the change:
      1. more evident
      2. less evident
      3. new ones

EXPERIENCES SINCE FIRST INTERVIEW

First I'd like to ask you about things you (may) have done since the last interview:

(STUDY-GROUP ONLY)

1. You and your child met with a doctor from the COPE team and some others at the school.

   a. Did they seem to have a good understanding of your child's difficulties?

   b. Did you get any new information about what might be causing the problems?

   c. Did you get any new ideas about further testing that should be done?

   d. Did you get any new ideas about how you or your child can deal with the problems?

   e. Do you think the teacher(s) got any new ideas about dealing with your child?

2. a. How was the outcome of the meeting with the doctor(s) at the school communicated to you?

   b. Do you think you had enough opportunities to talk with the doctor(s) about this?

   c. Do you think you had enough opportunities to talk with teachers and others at the school about this?

   d. Overall, do you think your child is doing better, about the same, or is doing worse as a result of seeing the doctor(s) at the school?

3. When you met the doctor(s) at the school, was it suggested that you and your child meet with other people or have any kind of treatment or follow-up? Yes No

   If "yes", Did that recommendation lead to any other meetings or treatments of any kind, or any kind of follow-up with your child? Yes No

   If "no", Why didn't you follow-up?

   If "yes", Could you please describe these?

4. The COPE program includes Family Support workers who sometimes work with families after the meeting with doctors.

   a. Was it suggested that you and/or your child meet with a Family support worker? Yes No

If "yes":

b. Did you and/or your child meet with the Family support worker? Yes No

If "no", Why not?

If "yes":

c. Did the Family support worker seem to understand your family's situation?

d. Did you get any ideas from him/her about how to make things better? (Elaborate)

e. Do you think it is good to have the Family support worker available after the meeting with the doctor? (Elaborate)

5. Do you think having the doctor at the school to meet with the teachers, you and your child was a good thing and made a positive impact, didn't have much impact, or was a bad thing and had a negative impact? Why?

   a. Taking into account your overall experience since your child first met the doctor(s) at the school (including doctor's visits, any follow-up assessments or treatments, and any changes that have resulted at home or school), are things any better, about the same, or worse for your child.

   b. What do you think has made things better (worse)?

   c. If you knew at the start what you know now, would you rather have the doctor(s) come to the school like this, or would you rather have it the way it was before, when the doctors didn't come to the school?

   d. Do you think it is better for the teachers and others at the school for the doctors to come to the school, or are the schools better able to work with children like yours without the doctors being there?

6. In what ways have you been involved in identifying your child's problems since meeting the doctor(s) at the school?

7. a. As a result of the meeting with the doctors, are you more aware of services available in Calgary for you and your child, or has it not made a difference on your level of awareness?

   b. As a result of the meeting with the doctor(s), are you more likely to use services available for your child, or has it not made a difference in your use of services?

(CONTROL-GROUP ONLY)

1. Since you were interviewed last time, have you talked to anyone at the school about any problems your child might be having at school or at home?

   - ☐ No - (Move on to Use of Health Professionals section)
   - ☐ Yes - (Proceed)

2. Who did you speak with (teacher, resource teacher etc.)

3. a. Did they seem to have a good understanding of your child's difficulties?

   b. Did you get any new information about what might be causing the problems?

   c. Did you get any new ideas about further testing that should be done?

   d. Did you get any new ideas about how you or your child can deal with the problems?

   e. Do you think the teacher(s) got any new ideas about dealing with your child?

4. When you met the people at the school, was it suggested that you and your child meet with other people or have any kind of treatment or follow-up? Yes No

   If "yes", Did that recommendation lead to any other meetings or treatments of any kind, or any kind of follow-up with your child? Yes No

   If "no", Why didn't you follow-up? (Move to Question 8)

   If "yes", Could you please describe these? (Proceed)

5. If the recommendation involved someone from outside the school ...

   a. How was the outcome of the meeting with them communicated to you?

   b. Do you think you had enough opportunities to talk with them about this?

   c. Do you think you had enough opportunities to talk with teachers and others at the school about this?

   d. Overall, do you think your child is doing better, about the same, or is doing worse as a result of seeing them?

6. Do you think the meetings, treatment or follow-up was a good thing and made a positive impact, didn't have much impact, or was a bad thing and had a negative impact? Why?

   a. Taking into account your overall experience since you or your child first met with these people, and any changes that have resulted at home or school, are things any better, about the same, or worse for your child.

   b. What do you think has made things better (worse)?

7. In what ways have you been involved in identifying your child's problems since meeting the people at the school?

8. a. As a result of the meeting at the school, are you more aware of services available in Calgary for you and your child, or has it not made a difference on your level of awareness?

   b. As a result of the meeting at the school, are you more likely to use services available for your child, or has it not made a difference in your use of services?

USE OF HEALTH PROFESSIONALS

1. Since our first interview, how many times have you seen or talked on the telephone with any of the following about ________'s physical, emotional or mental health?

   a) A general practitioner, family physician?
   (Enter 0 if none)

   b) A pediatrician?

   c) Another medical doctor (such as an orthopedist, or eye specialist)?

   d) A public health nurse or nurse practitioner?

   e) A dentist or orthodontist?

   f) A psychiatrist or psychologist?

   g) Child welfare worker or children's aid worker?

   h) Any other person trained to provide treatment or counsel, for example a speech therapist, a social worker?

   i) In the past 4 months, was ___________ an overnight patient in a hospital?

   YES
   NO

   j) If so, for what reason?

   1. Respiratory illness or disease
   2. Gastrointestinal illness or disease
   3. Injuries
   4. Other

   k) Does he/she take any of the following prescribed medication on a regular basis:

   1. Ventolin, inhalers or puffers for asthma?
   2. Ritalin?
   3. Tranquilizers or nerve pills?
   4. Anti-convulsants or anti-epilieptic pills?
   5. Other?

l) Has ___________ experienced any event or situation that has caused her/him a great amount of worry or unhappiness since we met last?

m) What was this?

1. Death of parents
2. Death in family (other than parents)
3. Divorce/separation of parents
4. Move
5. Stay in hospital
6. Stay in foster home
7. Other separation from parents
8. Illness/injury of a child
9. Illness/injury of a family member
10. Abuse/fear of abuse
11. Change in household members
12. Alcoholism or mental health disorder in family
13. Conflict between parents
14. Other

SCHOOL EXPERIENCE

1. Based on your knowledge of his/her schoolwork, including her/his report cards, how is your child doing in the following areas at school since we met last?

1 VERY WELL	2 WELL	3 AVERAGE	4 POORLY	5 VERY POORLY

a) Reading and other Language Arts?

b) Mathematics?

c) Written work such as composition?

d) Science?

2. At this point, how is she/he doing overall?

3. With regard to how he/she feels about school, how often does she/he look forward to going to school?

1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always

BEHAVIOR

Thinking specifically about the last 4 months, how does _________ seems to feel or act in these given situations?

Please use the answers never or not true, sometimes or somewhat true, or often or very often.

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

How often would you say that your child

1. Shows sympathy to someone who has made a mistake?

3. Can't sit still, is restless or hyperactive?

4. Destroys his/her own things?

5. Will try to help someone who has been hurt?

6. Steals at home?

7. Seems to be unhappy, sad or depressed?

8. Gets into many fights?

9. Volunteer to help clear up a mess someone else has made?

10. Is distractible, has trouble sticking to any activity?

11. When mad at someone, tries to get others to dislike that person?

12. Is not as happy as other children?

13. Destroys things belonging to her/his family, or other children?

14. If there is a quarrel or dispute, will try to stop it?

15. Fidgets?

16. Is disobedient at school?

17. Can't concentrate, can't pay attention for long?

18. Is too fearful or anxious?

19. When mad at someone, becomes friends with another to get revenge?

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

20. Is impulsive, acts without thinking?

21. Tells lies or cheats?

22. Offers to help other children (friend, brother or sister) who are having difficulty with a task?

23. Is worried?

24. Has difficulty awaiting turn in games or groups?

25. When another child accidentally hurts him/her (such as by bumping into her/him) assumes that the other child meant to do it, and then reacts with anger and fighting?

26. Tends to do things on his/her own – is rather solitary?

27. When mad at someone, says bad things behind the other's back?

28. Physically attacks people?

29. Comforts a child (friend, brother or sister) who is crying or upset?

30. Cries a lot?

31. Vandalizes?

32. Gives up easily?

33. Threatens people?

34. Spontaneously helps to pick up objects which another child has dropped (e.g., books, pencils, etc.)

35. Cannot settle to anything for more than a few moments?

36. Appears miserable, unhappy, tearful or distressed?

37. Is cruel, bullies or is mean to others?

38. Stares into space?

39. When mad at someone, says to others, "Let's not be with him/her"?

40. Is nervous, high-strung or tense?

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

41. Kicks, bites, hits other children?

42. Will invite bystanders to join in a game?

43. Steals outside the home?

44. Is attentive?

45. Has trouble enjoying him/herself?

46. Helps other children (friends, brother or sister) who are feeling sick?

47. When mad at someone, tells the other one's secrets to a third person?

48. Takes the opportunity to praise the work of less able children?

RELATIONSHIPS

Think about the last 4 months for the next questions about your child's relationships with friends, family and others.

1. About how many days a week does he/she do things with friends?

    1. Never
    2. 1 day a week
    3. 2-3 days a week
    4. 4-5 days a week
    5. 6-7 days a week

2. About how many close friends does she/he have?

    1. None
    2. 1
    3. 2 or 3
    4. 4 or 5
    5. 6 or more

3. When it comes to meeting new children and making new friends is he/she:

    1. Somewhat shy?
    2. About average?
    3. Very outgoing – makes friends easily?

1 Very Well	2 Quite Well	3 Pretty Well	4 Not Too Well	5 Not Well At All	6 Not Applicable
No Problems	Hardly Any Problems	Occasional Problems	Frequent Problems	Constant Problems	

4. During the past 4 months, how well has _______________ gotten along with other kids, such as friends or classmates (excluding brothers or sisters)

5. During the last 4 months, how well has he/she gotten along with her/his teacher(s) at school?

6. During the past 4 months, how well has he/she gotten along with his/her parent(s)?

7. During the past 4 months, how well has _______________ gotten along with her/his brother(s)/sister(s)

PARENTING

1. Has your parenting changed during the last 4 months?
    YES
    NO

2. If YES, in what ways has your parenting changed during the last 4 months?
    a. new strategies
    b. understanding of problem
    c. counselling

PARENT SURVEY #3 - INTERVIEWER'S COPY

This is the third and final survey we are asking you to complete as part of our assessment of the COPE program.

Some of the questions ask about your overall experience with the COPE program since the first interview, about 8 months ago, and some concern the experiences you and your child have had since the 2nd interview about 4 months ago.
There are no right and wrong answers for these questions. Please answer the questions as accurately as possible.

The interview consists of 3 sections. They are:

1. personal information
2. your overall experience since the FIRST interview
3. experiences since you were LAST interviewed
    - use of health professionals
    - school experience
    - behavior
    - parenting

Before we go on, do you have any comments, questions, or feedback about our last interview?

SECTION 1: PERSONAL INFORMATION

1. Your name: state, don't ask (from previous interviews)
2. Child's name: state, don't ask (from previous interviews)
3. Your relationship to child: state, don't ask (from previous interviews)
4. In our previous interviews, you described in your own words the problems your child was having.
    a. How would you describe your child's problems, if any, at this point?
    b. Have there been any changes in your child's emotional, behavioral, or learning problems since our first interview?
    c. Describe the change:
        1. more problematic
        2. less problematic
        3. new problems
5. In our previous interviews, you described in your own words the gifts or strengths that your child has.
    a. How would you describe those gifts or strengths at this point?
    b. Have there been any changes in your child's strengths since our first interview?
    c. Describe the change:
        1. more evident
        2. less evident
        3. new ones

SECTION 2: OVERALL EXPERIENCE SINCE ROUND 1 INTERVIEW

(STUDY-GROUP ONLY)

For the next set of questions, please think about your overall experience since you and your child were first introduced to COPE about 8 months ago.

1. You and your child met with a doctor from the COPE team just after our first interview.

   a. Did they seem to have a good understanding of your child's difficulties?

   b. Did you get any new information about what might be causing the problems?

   c. Did you get any new ideas about further testing that should be done?

   d. Did you get any new ideas about how you or your child can deal with the problems?

   e. Do you think the teacher(s) got any new ideas about dealing with your child?

2. Have you or your child had contact with other professionals (psychologists, learning specialists, etc.)? Yes No

   If yes,

   a. Did they seem to have a good understanding of your child's difficulties?

   b. Did you get any new information about what might be causing the problems?

   c. Did you get any new ideas about further testing that should be done?

   d. Did you get any new ideas about how you or your child can deal with the problems?

   e. Do you think the teacher(s) got any new ideas about dealing with your child?

3. The COPE program includes Family Support workers who sometimes work with families after the meeting with doctors.

   a. Was it suggested that you and/or your child meet with a Family support worker? Yes No

   If yes,

   b. Did you and/or your child meet with the Family support worker? Yes No

   If "no", Why not?

If yes,

c. Did the Family support worker seem to understand your family's situation?

d. Did you get any ideas from him/her about how to make things better? (Elaborate)

e. Do you think it is good to have the Family support worker available after the meeting with the doctor? (Elaborate)

4. Do you think having the doctor at the school to meet with the teachers, you and your child was a good thing and made a positive impact, didn't have much impact, or was a bad thing and had a negative impact? Why?

   a. Taking into account your overall experience since your child first met the doctor(s) at the school (including doctor's visits, any follow-up assessments or treatments, and any changes that have resulted at home or school), are things any better, about the same, or worse for your child.

   b. What do you think has made things better (worse)?

   c. If you knew at the start what you know now, would you rather have the doctor(s) come to the school like this, or would you rather have it the way it was before, when the doctors didn't come to the school?

   d. Do you think it is better for the teachers and others at the school for the doctors to come to the school, or are the schools better able to work with children like yours without the doctors being there?

5. In what ways have you been involved in identifying your child's problems since meeting the doctor(s) at the school?

6. a. As a result of the meeting with the doctors or others involved with the COPE program, are you more aware of services available in Calgary for you and your child, or has it not made a difference on your level of awareness?

   b. As a result of the meeting with the doctors or others involved with the COPE program, are you more likely to use services available for your child, or has it not made a difference in your use of services?

7. Since you were first interviewed have you found any resources ON YOUR OWN to help you and your child deal with any problems your child might be having at school or at home? Yes No

If no, **GO** ~~TO~~ **Question #10** ~~SECTION 3 (EXPERIENCE BETWEEN ROUND 2 AND ROUND 3)~~

If yes, continue:

8. What were those resources?

   a. Did they seem to have a good understanding of your child's difficulties?

b. Did you get any new information about what might be causing the problems?

c. Did you get any new ideas about further testing that should be done?

d. Did you get any new ideas about how you or your child can deal with the problems?

e. Do you think the teacher(s) got any new ideas about dealing with your child?

9. Do you think the resources you found were good things and made a positive impact, didn't have much impact, or were bad things and had a negative impact? Why?

   a. Taking into account your overall experience since you or your child first met with these people, and any changes that have resulted at home or school, are things any better, about the same, or worse for your child.

   b. What do you think has made things better (worse)?

10. If you had the opportunity to make any changes to the COPE program in helping children with social, emotional and behavioral problems, what change would you make?

GO TO SECTION 3 (EXPERIENCE BETWEEN ROUND 2 AND ROUND 3)

SECTION 2: OVERALL EXPERIENCE SINCE ROUND 1 INTERVIEW

(CONTROL-GROUP ONLY)

For the next set of questions, please think about your overall experience since you and your child were FIRST interviewed by COPE research about 8 months ago.

1. Since you were first interviewed, have you talked to anyone at the school about any problems your child might be having at school or home? Yes No

   If no, GO TO Question 7
   If yes, continue:

2. Who did you speak with (teacher, resource teacher etc.)

3. a. Did they seem to have a good understanding of your child's difficulties?

   b. Did you get any new information about what might be causing the problems?

   c. Did you get any new ideas about further testing that should be done?

   d. Did you get any new ideas about how you or your child can deal with the problems?

   e. Do you think the teacher(s) got any new ideas about dealing with your child?

4. Do you think the meetings, treatment or follow-up that were suggested by the school were good things and made a positive impact, didn't have much impact, or were bad things and had a negative impact? Why?

   a. Taking into account your overall experience since you or your child first met with these people, and any changes that have resulted at home or school, are things any better, about the same, or worse for your child.

   b. What do you think has made things better (worse)?

5. In what ways have you been involved in identifying your child's problems since meeting the people at the school?

6. a. As a result of the meeting at the school, are you more aware of services available in Calgary for you and your child, or has it not made a difference on your level of awareness?

   b. As a result of the meeting at the school, are you more likely to use services available for your child, or has it not made a difference in your use of services?

7. Have you or your child had contact with other professionals (psychologists, learning specialists, etc.)? Yes No

If yes,

a. Did they seem to have a good understanding of your child's difficulties?

b. Did you get any new information about what might be causing the problems?

c. Did you get any new ideas about further testing that should be done?

d. Did you get any new ideas about how you or your child can deal with the problems?

e. Do you think the teacher(s) got any new ideas about dealing with your child?

8. Since you were first interviewed have you found any resources ON YOUR OWN to help you and your child deal with any problems your child might be having at school or at home? Yes No

If no, **GO TO SECTION 3** (EXPERIENCE BETWEEN ROUND 2 AND ROUND 3)
If yes, continue:

9. What were those resources?

a. Did they seem to have a good understanding of your child's difficulties?

b. Did you get any new information about what might be causing the problems?

c. Did you get any new ideas about further testing that should be done?

d. Did you get any new ideas about how you or your child can deal with the problems?

e. Do you think the teacher(s) got any new ideas about dealing with your child?

10. Do you think the resources you found were good things and made a positive impact, didn't have much impact, or were bad things and had a negative impact? Why?

a. Taking into account your overall experience since you or your child first met with these people, and any changes that have resulted at home or school, are things any better, about the same, or worse for your child.

b. What do you think has made things better (worse)?

GO TO SECTION 3 (EXPERIENCE BETWEEN ROUND 2 AND ROUND 3)

SECTION 3: EXPERIENCES BETWEEN ROUND 2 AND ROUND 3

(STUDY-GROUP ONLY)

For the rest of the questions, I'd like you to think about things that (may) have happened since the LAST interview about 4 months ago:

1. Have you or your child had any further contact with a doctor from the COPE team? Yes No

If no, **GO TO Question 4**
If yes, continue:

   a. Did they seem to have a good understanding of your child's difficulties?

   b. Did you get any new information about what might be causing the problems?

   c. Did you get any new ideas about further testing that should be done?

   d. Did you get any new ideas about how you or your child can deal with the problems?

   e. Do you think the teacher(s) got any new ideas about dealing with your child?

2. How was the outcome of the meeting with the doctor(s) communicated to you?

   a. Do you think you had enough opportunities to talk with the doctor(s) about this?

   b. Do you think you had enough opportunities to talk with teachers and others at the school about this?

   c. Overall, do you think your child is doing better, about the same, or is doing worse as a result of seeing the doctor(s) at the school this time?

3. When you met the doctor(s) this time, was it suggested that you and your child meet with other people or have any kind of treatment or follow-up? Yes No

   If "yes", Did that recommendation lead to any other meetings or treatments of any kind, or any kind of follow-up with your child? Yes No

      If "no", Why didn't you follow-up?

      If "yes", Could you please describe these?

4. If you or your child have had contact with other professionals (psychologists, learning specialists, etc.), did that happen since the last interview? Yes No

5. If you have seen a COPE Family Support worker, did that happen since you were last interviewed? Yes No

B-4

SECTION 3: EXPERIENCES BETWEEN ROUND 2 AND ROUND 3

(CONTROL-GROUP ONLY)

For the rest of the questions, I'd like you to think about things that (may) have happened since the LAST interview about 4 months ago:

1. Since you were interviewed last time, have you talked to anyone further at the school about any problems your child might be having at school or at home? Yes No

   If No, **GO TO Question 9**
   If Yes, continue:

2. Who did you speak with (teacher, resource teacher etc.) this time?

3. a. Did they seem to have a good understanding of your child's difficulties?

   b. Did you get any new information about what might be causing the problems?

   c. Did you get any new ideas about further testing that should be done?

   d. Did you get any new ideas about how you or your child can deal with the problems?

   e. Do you think the teacher(s) got any new ideas about dealing with your child?

4. When you met the people at the school this time, was it suggested that you and your child meet with other people or have any kind of treatment or follow-up?
   Yes No

   If "yes", Did that recommendation lead to any other meetings or treatments of any kind, or any kind of follow-up with your child? Yes No

   If "no", Why didn't you follow-up? (Move to Question 7)

   If "yes", Could you please describe these? (Proceed)

5. If the recommendation this time involved someone from outside the school …

   a. How was the outcome of the meeting with them communicated to you?

   b. Do you think you had enough opportunities to talk with them about this?

   c. Do you think you had enough opportunities to talk with teachers and others at the school about this?

d. Overall, do you think your child is doing better, about the same, or is doing worse as a result of seeing them?

6. Do you think the meetings, treatment or follow-up was a good thing and made a positive impact, didn't have much impact, or was a bad thing and had a negative impact? Why?

   a. Taking into account your overall experience since you or your child first met with these people, and any changes that have resulted at home or school, are things any better, about the same, or worse for your child.

   b. What do you think has made things better (worse)?

7. In what ways have you been involved in identifying your child's problems since meeting the people at the school?

8. a. As a result of the meeting at the school, are you more aware of services available in Calgary for you and your child, or has it not made a difference on your level of awareness?

   b. As a result of the meeting at the school, are you more likely to use services available for your child, or has it not made a difference in your use of services?

9. If you or your child have had contact with other professionals (psychologists, learning specialists, etc.) did that happen since the last interview?

USE OF HEALTH PROFESSIONALS

1. Since our last interview, how many times have you seen or talked on the telephone with any of the following about ________'s physical, emotional or mental health?

   a) A general practitioner, family physician?
   (Enter 0 if none)

   b) A pediatrician?

   c) Another medical doctor (such as an orthopedist, or eye specialist)?

   d) A public health nurse or nurse practitioner?

   e) A dentist or orthodontist?

   f) A psychiatrist or psychologist?

   g) Child welfare worker or children's aid worker?

   h) Any other person trained to provide treatment or counsel, for example a speech therapist, a social worker?

   i) Since our last interview, was ________ an overnight patient in a hospital?

   YES
   NO

   j) If so, for what reason?

   1. Respiratory illness or disease
   2. Gastrointestinal illness or disease
   3. Injuries
   4. Other

   k) Does he/she take any of the following prescribed medication on a regular basis:

   1. Ventolin, inhalers or puffers for asthma?
   2. Ritalin?
   3. Tranquilizers or nerve pills?
   4. Anti-convulsants or anti-epileptic pills?
   5. Other?

l) Has ___________ experienced any event or situation that has caused her/him a great amount of worry or unhappiness since we met last?

m) What was this?

1. Death of parents
2. Death in family (other than parents)
3. Divorce/separation of parents
4. Move
5. Stay in hospital
6. Stay in foster home
7. Other separation from parents
8. Illness/injury of a child
9. Illness/injury of a family member
10. Abuse/fear of abuse
11. Change in household members
12. Alcoholism or mental health disorder in family
13. Conflict between parents
14. Other

SCHOOL EXPERIENCE

1. Based on your knowledge of his/her schoolwork, including her/his report cards, how is your child doing in the following areas at school since the last interview?

1 VERY WELL	2 WELL	3 AVERAGE	4 POORLY	5 VERY POORLY

a) Reading and other Language Arts?

b) Mathematics?

c) Written work such as composition?

d) Science?

2. At this point, how is she/he doing overall?

3. With regard to how he/she feels about school, how often does she/he look forward to going to school?

1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always

BEHAVIOR

Thinking specifically about the time since our last interview, how does _________ seem to feel or act in these given situations?

Please use the answers never or not true, sometimes or somewhat true, or often or very often.

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

How often would you say that your child

1. Shows sympathy to someone who has made a mistake?

3. Can't sit still, is restless or hyperactive?

4. Destroys his/her own things?

5. Will try to help someone who has been hurt?

6. Steals at home?

7. Seems to be unhappy, sad or depressed?

8. Gets into many fights?

9. Volunteer to help clear up a mess someone else has made?

10. Is distractible, has trouble sticking to any activity?

11. When mad at someone, tries to get others to dislike that person?

12. Is not as happy as other children?

13. Destroys things belonging to her/his family, or other children?

14. If there is a quarrel or dispute, will try to stop it?

15. Fidgets?

16. Is disobedient at school?

17. Can't concentrate, can't pay attention for long?

18. Is too fearful or anxious?

19. When mad at someone, becomes friends with another to get revenge?

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

20. Is impulsive, acts without thinking?

21. Tells lies or cheats?

22. Offers to help other children (friend, brother or sister) who are having difficulty with a task?

23. Is worried?

24. Has difficulty awaiting turn in games or groups?

25. When another child accidentally hurts him/her (such as by bumping into her/him) assumes that the other child meant to do it, and then reacts with anger and fighting?

26. Tends to do things on his/her own – is rather solitary?

27. When mad at someone, says bad things behind the other's back?

28. Physically attacks people?

29. Comforts a child (friend, brother or sister) who is crying or upset?

30. Cries a lot?

31. Vandalizes?

32. Gives up easily?

33. Threatens people?

34. Spontaneously helps to pick up objects which another child has dropped (e.g., books, pencils, etc.)

35. Cannot settle to anything for more than a few moments?

36. Appears miserable, unhappy, tearful or distressed?

37. Is cruel, bullies or is mean to others?

38. Stares into space?

39. When mad at someone, says to others, "Let's not be with him/her"?

40. Is nervous, high-strung or tense?

1 Never Or Not True	2 Sometimes Or Somewhat True	3 Often Or Very True

41. Kicks, bites, hits other children?

42. Will invite bystanders to join in a game?

43. Steals outside the home?

44. Is attentive?

45. Has trouble enjoying him/herself?

46. Helps other children (friends, brother or sister) who are feeling sick?

47. When mad at someone, tells the other one's secrets to a third person?

48. Takes the opportunity to praise the work of less able children?

RELATIONSHIPS

Please think about experiences since our last interview for the next questions about your child's relationships with friends, family and others.

1. About how many days a week does he/she do things with friends?

    1. Never
    2. 1 day a week
    3. 2-3 days a week
    4. 4-5 days a week
    5. 6-7 days a week

2. About how many close friends does she/he have?

    1. None
    2. 1
    3. 2 or 3
    4. 4 or 5
    5. 6 or more

3. When it comes to meeting new children and making new friends is he/she:

    1. Somewhat shy?
    2. About average?
    3. Very outgoing – makes friends easily?

1 Very Well	2 Quite Well	3 Pretty Well	4 Not Too Well	5 Not Well At All	6 Not Applicable
No Problems	Hardly Any Problems	Occasional Problems	Frequent Problems	Constant Problems	

4. Since our last interview, how well has _______________ gotten along with other kids, such as friends or classmates (excluding brothers or sisters)

5. Since our last interview, how well has he/she gotten along with her/his teacher(s) at school?

6. Since our last interview, how well has he/she gotten along with his/her parent(s)?

7. Since our last interview, how well has _______________ gotten along with her/his brother(s)/sister(s)

PARENTING

1. Has your parenting changed during the period since our last interview?
    - YES
    - NO

2. If YES, in what ways has your parenting changed during this time?
    a. new strategies
    b. understanding of problem
    c. counseling

INTERVIEWING GUIDELINES FOR THE COPE CHILD SURVEY

QUESTIONNAIRE VERSIONS:

There are two versions of some of the questions in the interview. Select the version you are administering based on your judgment of the child's comprehension of the questions.

1. Version #1
   This is the original version and is to be used as a first preference. Where there are choices for you to make, the wording that goes with this version is printed at the left of the boxes with dotted borders (no shading).

2. Version #2
   The wording of some questions has been changed to help the younger child or the less able child understand what is being asked. Where there are choices for you to make, the wording that goes with this version is printed in the shaded area to the right.

Example:

Ques#	Version #1	Version #2
A5	About how many days a week do you do things with friends outside of school hours?	How often do you do things with friends away from school?

QUESTIONING METHODS:

There are two questioning methods that you may use for Version #2. Either present the questions as written OR present the question as a DIRECT QUESTION (i.e. to solicit a yes/no answer) and then proceed to narrow down the frequency according to the scale being used for that question.

Example for the above question:
Direct question: Do you do things with your friends away from school? "yes" How often ...every day? "no" once a week? etc.

ON THE RECORDING SHEET:

Please indicate on the record sheet which version you have used and whether the questioning method was DIRECT QUESTIONING (DQ).

If you have used these options and still have judged that the child has not understood the question, record their answer BUT ALSO cross out the number of that question on the record sheet.

SCALES

When multiple questions use the same scale, the scale is printed only once, above the applicable questions. The scale boxes have bolded, solid borders. In brackets to the right of the scale box is the question that scales is to be used for. The same is indicated on the "response prompt" sheet to be given to the child for reference in answering that series of questions. This same method is used for the Parent interview.

Hope this is mildly clear! Don't hesitate to call if you have questions after you have had a chance to look at the instruments.

C.O.P.E.

Community Outreach in Pediatrics/Psychiatry and Education
Parkdale Centre, 728 - 32 St. N.W.
Calgary, Alberta, Canada
T2N 2V9

COPE CHILD QUESTIONNAIRE #1

This survey asks questions about your family, friends, how you feel and what you like to do.

Your answers will help in our study of the needs of children in the Calgary school system.

This is not a test and there are **no right or wrong answers**.

Some questions may seem personal and some are about things which not everybody does.

Take your time and please be sure to answer each question based on what you really think.

You can choose whether or not to fill out this questionnaire. If you need help with any questions, you may ask the interviewer.

SECTION A FRIENDS AND FAMILY

(A1-A4)

False	Mostly False	Sometimes	Mostly True	True
0	1	2	3	4

A1 I have a lot of friends.
A2 I get along with kids easily.
A3 Other kids want me to be their friend.
A4 Most other kids like me.

(A5)

Never	Less than once a week	1 day a week	2 or 3 days a week	4 or 5 days a week	Everyday
0	1	2	3	4	5

A5	About how many days a week do you do things with friends outside of school hours?	How often do you do things with friends away from school?

A6 How many close friends do you have?

A7	Other than your friends, do you have anyone else in particular you can talk to about yourself or your problems?	Besides your friends, are there other people you can talk to about yourself or any problems you are having?

Yes (A8)

1. Mother
2. Father
3. Stepmother
4. Stepfather
5. Brother
6. Sister
7. Grandparent
8. Other relative
9. A friend of the family
10. Sitter or babysitter
11. Parent's boyfriend/girlfriend
12. Teacher
13. Coach or leader
14. Other

No

(A9-A12)

No Contact	No problems	Hardly any problems	Problems once in a while	Frequent problems	Constant Problems
0	1	2	3	4	5

A9. During the past 6 months, how well have you gotten along with your friends or classmates?

A10. During the past 6 months, how well have you gotten along with your mother *(step mother or foster mother)?*

A11. During the past 6 months, how well have you gotten along with your father *(step father or foster father)*?

A12. During the past 6 months, how well have you gotten along with your brothers and sisters *(step brothers and sisters or foster brothers and sisters)*?

SECTION B SCHOOL

(B1)

Very much	Quite a bit	A little	Not very much	I hate school
0	1	2	3	4

B1	How do you feel about school? "I like school …."	How much do you like school?

(B2)

Very well	Well	Average	Poorly	Very poorly
0	1	2	3	4

B2. How well do you think you are doing in your school work?

(B3)

Very Important	Important	Kind of important	Not very important	Not at all important
0	1	2	3	4

B3.	How important is it to you to get good grades in school?	How important do you think it is to get good marks in school?

(B4)

False	Mostly false	Sometimes	Mostly true	True
0	1	2	3	4

B4. I like mathematics.

(B5-B17)

All the time	Most of the time	Some of the time	Rarely	Never
0	1	2	3	4

B5. I feel safe **at** school.

B6. I feel safe on my way **to** and **from** school.

B7.	Children say nasty and unpleasant things to me at school.	At school, children say nasty and unpleasant things to me.

B8.	I am bullied **in** school.	I get picked on **in** school.

B9.	I am bullied on my way **to** and **from** school.	I get picked on my way **to** and **from** school.

B10. I feel like an outsider (left out of things) at my school.

B11	If I need extra help, my teacher gives it to me.	My teacher gives me extra help if I need it.

B12. My teacher treats me fairly.

B13.	If I have problems at school, my parents are ready to help.	My parents are ready to help me if I have problems at school.

B14. My parents encourage me to do well at school.

B15.	My parents expect too much of me at school.	My parents expect me to do better than I am able to do at school.

B16. I have a place at home to do homework or study.

B17. When my teacher gives me homework, I do it.

Section C About Me

(C1)

False	Mostly false	Sometimes	Mostly true	True
0	1	2	3	4

C1.

a. In general, I like the way I am.
b. Overall, I have a lot to be proud of.
c. A lot of things about me are good.
d. When I do something, I do it well.
e. I am good looking.
f. I have a pleasant looking face.
g. Other kids think I am good looking.
h. I have a good looking body.

SECTION D FEELINGS AND BEHAVIORS

(D1)

Never or not true	Sometimes or somewhat true	Often or very true
1	2	3

D1.

a. I show sympathy to (feel sorry for) someone who has made a mistake.
b. I can't sit still, am restless or hyperactive.
c. I destroy my own things.
d. I will try to help someone who has been hurt.
e. I steal at home
f. I am unhappy, sad or depressed.
g. I get into many fights.

h.	I volunteer to help clear up a mess someone else has made.	I offer to help clean up a mess that somebody else has made.

i. I am distractible, have trouble sticking to any activity.

j.	I try when I am mad at someone, to get others to dislike him/her.	When I am mad at someone, I try to get other people to not like him/her.

k. I am not as happy as other people my age.

l.	I destroy things belonging to my family or other kids.	I destroy or wreck things that belong to my family or other kids.

Never or not true	Sometimes or somewhat true	Often or very true
1	2	3

m.	I will try, if there is a argument, to stop it	If there is an argument, I will try to stop it.

n. I fidget.

o.	I am disobedient at school.	I do not do what I am told to do at school.

p.	I can't concentrate, can't pay attention.	I have a hard time concentrating or paying attention.

q.	I am too fearful or anxious.	I am too afraid or nervous about things.

r.	When I am mad at someone, I become friends with another as revenge.	When I am mad at someone, I make friends with someone else to get back at them.

s. I am impulsive, act without thinking.
t. I tell lies or cheat.

u.	I offer to help other kids (*friend, brother or sister*) who are having difficulty with a task.	I offer to help other kids who are having trouble doing something.

v. I am worried.

w.	I have difficulty awaiting my turn in games or groups.	I have a hard time waiting for my turn in games or groups.

x. I assume, when another kid accidentally hurts me (such as bumping into me), that the other kid meant to do it, and then I react with anger and fighting.

y. I tend to do things on my own – am rather solitary.
z. When mad at someone, I say bad things behind his/her back.
aa. I physically attack people.

bb.	I comfort a friend, brother or sister who is crying or upset.	I comfort other kids when they are crying or upset.

cc. I cry a lot.
dd. I vandalize.
ee. I give up easily

Never or not true	Sometimes or somewhat true	Often or very true
1	2	3

ff. I threaten people.

gg.	I help to pick up objects which another kid has dropped (*e.g. pencils, books*).	I help to pick up things that other kids have dropped (*e.g. pencils, books*).

hh.	I cannot settle to anything for more than a few moments.	I cannot focus on things for more than a few minutes.

ii. I feel miserable, unhappy, tearful, or distressed.
jj. I am cruel, bully, or am mean to others.
kk. I stare into space.

ll.	When mad at someone, I say to others: let's not be with him/her.	When I am mad at someone, I say to others: Let's not play with him or her.

mm. I am nervous, high-strung or tense.
nn. I kick, bite, hit other people my age.
oo. I will invite bystanders (EXPLAIN TERM IF NECESSARY) to join in a game.
pp. I steal outside the home.

qq.	I am inattentive, have difficulty paying attention to someone.	I have difficulty paying attention to someone.

rr. I have trouble enjoying myself.
ss. I help other people my age (*friends, brother, sister*) who are feeling sick.

tt.	When mad at someone, I tell the other one's secrets to a third person.	When I'm made at people, I tell their secrets to other people.

uu.	I take the opportunity to show support for the work of other people my age who can't do things as well as me.	I tell other kids who can't do things as well as I can that I like what they are doing or that they are doing well.

(D2)

Never	Once or twice	Three or four times	5 or more times
1	2	3	4

D2. In the past year, about how many times …

a. did you stay out later than your parents said you should?
b. did you stay out all night without permission?
c. did you skip a day of school without permission?
d. did you get drunk?
e. were you questioned by the police about anything you might have done such as stealing, damaging property or anything else?
f. did you run away from home?

D3. In the past year were you part of a group that did bad things? Yes No

SECTION E MY PARENTS AND ME

(E1)

Never	Rarely or Hardly ever	Sometimes	Often	Always
0	1	2	3	4

E1. My parents (*or step parents or foster parents)* ...

a. smile at me.
b. want to know exactly where I am and what I am doing.
c. soon (*quickly*) forget a rule they have made.
d. praise me
e. let me go out any evening I want.
f. tell me what time to be home when I go out.

g.	nag me about little things.	bug me about things that are not important.

h. listen to my ideas and opinions
i. and I solve a problem together whenever we disagree about something.

j.	only keep rules when it suits them.	only stick to the rules they make when they feel like it.

k. make sure I know I am appreciated.

l.	Threaten punishment more often than they use it.	Threaten to punish me more often than they really do it.

m. speak of (*talk about*) the good things I do.

n.	Find out about my misbehavior	Find out when I do something I'm not supposed to do.

o. enforce a rule or do not enforce a rule depending upon their mood (EXPLAIN TERM IF NECESSARY).
p. hit me or threaten to do so.
q. Seem proud of the things I do.

SECTION G SMOKING, DRINKING AND DRUGS

G1. Have you ever tried cigarette smoking, eve just a few puffs?

Yes GO TO G2

No Which of the following are the **most important reasons** why you have never tried smoking?

1. Most of my friends do not smoke.
2. My parents do not smoke.
3. I think it is bad for my health.
4. I think I might not be able to stop.
5. It is against the law for me to smoke.
6. I would get into trouble with my parents or teachers.
7. I would get into trouble with the police.
8. I cannot get cigarettes or afford them.
9. I have other things I enjoy doing.
10. Some other reason.

GO TO G5

(G2)

Never	1 or 2 times	A few times a year	1 or 2 times a month	1 or 2 times a week	Every day
0	1	2	3	4	5

G2. How often do you smoke cigarettes?

IF "0" OR "1" GO TO G5

G3	If you have smoked one or more cigarettes every day for at least 7 days in a row, how old were you when you first did so?	How old were you when you first did so?

G4. On the days that you smoke, about how many cigarettes do you usually smoke?

G5. How many of your friends smoke?

G9. How many of your friends drink alcohol?

G10. Have you ever tried drugs or sniffed glue or solvents?

NO GOT TO G13

YES

(G11)

Never	1 or 2 times	A few times a year	1 or 2 times a month	1 or 2 times a week	Every day
0	1	2	3	4	5

G11	If you have used the following substances, how often do you …	How often do you …

a. use marijuana ("pot", "grass") or hash?
b. sniff glue or solvents like nail polish remover, paint thinner or gasoline?
c. use other drugs like cocaine, crack, speed, LSD/acid?

G12.	If you have used drugs (such as marijuana, glue, solvents or cocaine, etc.) how old were you when you first did so?	How old were you when you first used drugs?

G13. How many of your friends have tried drugs or sniffed glue or solvents?

SECTION H ACTIVITIES

(H1)

Never	Less than once a week	2 or 3 times a week	4 or more times a week
1	2	3	4

H1. In the past year (last 12 months), how often have you …

a. played sports or done physical activities **without** a coach or instructor (biking, skateboarding etc.)?

b. played sports **with** a coach or instructor, other than in gym class (school teams, swimming lessons etc.)?

c.	taken part in dance, gymnastics or cheerleading groups or lessons, other than in gym class?	taken part in dance or gymnastics outside of gym class? Was it lessons or in a club?

d.	taken part in art, drama or music groups, clubs or lessons outside of class?	taken part in art, drama or music outside of class? Was it lessons or in a club?

e.	taken part in clubs or groups such as Guides or Scouts, 4-H club, community, church or other religious groups?	taken part in Guides or Scouts, community groups, or church groups?

f. had a job (a paper route, babysitting, etc.)?

g. played computer or video games?

h. Watched TV?

(H2)

None	1 to 2 hours a day	3 or 4 hours a day	5 to 6 hours a day	7 or more hours a day
0	1	2	3	4

H2. On average, about how many hours a day do you watch TV?

(H3)

Every day	a few times a week	Once a week	a few times a month	Less than once a month	Almost never
0	1	2	3	4	5

H3. How often do you read for fun (not for school)?

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Parkdale Centre, 728 - 32 St. N.W.
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COPE CHILD QUESTIONNAIRE #2

I spoke with you, or someone like me from our team, spoke with you about 4 months ago. Do you remember that meeting? Yes No

> If "yes", proceed.
>
> If "no": Well, about 4 months ago, we came to your school and asked you to come out of class and answer a whole bunch of questions. In that interview, we asked you some questions about your family and friends, about how you felt about things and about what you liked to do. This time, I will ask you some questions like that again to see how you think and feel about those things now.

Your answers will help in our study of the needs of children in the Calgary school system.

This is not a test and there are **no right or wrong answers**.

Some questions may seem personal and some are about things which not everybody does.

Take your time and please be sure to answer each question based on what you really think.

You can choose whether or not to fill out this questionnaire. If you need help with any questions, you may ask the interviewer.

SECTION 0

First I'd like to ask you about things you (may) have done since the last interview.

(STUDY-GROUP ONLY):

1. We understand that you've met with a doctor or a group of doctors at your school:
    a. How many times did you meet with the doctor(s) at the school?
    b. Do you know why you met with them?
    c. What happened at the meeting(s)?
    d. What did you learn from the doctor(s)?
    e. Are things any better for you or worse for you since you first saw the doctor(s) at school? (Prompt: In what ways)
2. Have you met with anyone else to talk about the same things as you talked about with the doctor(s)?
    a. Do you know who that person was?
    b. Do you know why you met with them?
    c. What happened at that meeting?
    d. Did you learn anything from them?
    e. Are things any better for you or worse for you since you first saw him/her? (Prompt: In what ways)
3. Did you meet with anyone else than (him/her) to talk about these things?
    a. Do you know who that person was?
    b. Do you know why you met with them?
    c. What happened at that meeting?
    d. Did you learn anything from them?
    e. Are things any better for you or worse for you since you first saw him/her? (Prompt: In what ways)

(CONTROL-GROUP ONLY)

1. Since the last time we asked you questions, have you talked with anyone at school (like your teacher or anyone else) since the about any problems you might be having at school or at home?

    a. Could you tell me about that?

    b. Was your mom or dad with you when you talked to them?

    c. What happened at that meeting?

    d. What did you learn from that meeting?

    e. Are things any better for you or worse for you since you talked with them at school? (Prompt: In what ways)

2. Have you met with anyone else at school or outside of school to talk about the same things as you talked about with the people at school?

    a. Do you know who that person was?

    b. Do you know why you met with them?

    c. What happened at that meeting?

    d. Did you learn anything from them?

    e. Are things any better for you or worse for you since you first saw him/her? (Prompt: In what ways)

SECTION A FRIENDS AND FAMILY

Now I'm going to ask you a few questions about your friends and family (introduce response set).

(A1-A4)

False	Mostly False	Sometimes	Mostly True	True
0	1	2	3	4

A1 I have a lot of friends.
A2 I get along with kids easily.
A3 Other kids want me to be their friend.
A4 Most other kids like me.

(A5)

Never	Less than once a week	1 day a week	2 or 3 days a week	4 or 5 days a week	Everyday
0	1	2	3	4	5

A5	About how many days a week do you do things with friends outside of school hours?	How often do you do things with friends away from school?

A6 How many close friends do you have?

A7	Other than your friends, do you have anyone else in particular you can talk to about yourself or your problems?	Besides your friends, are there other people you can talk to about yourself or any problems you are having?

Yes (A8)

1. Mother
2. Father
3. Stepmother
4. Stepfather
5. Brother
6. Sister
7. Grandparent
8. Other relative
9. A friend of the family
10. Sitter or babysitter
11. Parent's boyfriend/girlfriend
12. Teacher
13. Coach or leader
14. Other

No

No Contact	No problems	Hardly any problems	Problems once in a while	Frequent problems	Constant Problems
0	1	2	3	4	5

A9. During the last 4 months, how well have you gotten along with your friends or classmates?

A10. During the last 4 months, how well have you gotten along with your mother *(step mother or foster mother)*?

A11. During the last 4 months, how well have you gotten along with your father *(step father or foster father)*?

A12. During the last 4 months, how well have you gotten along with your brothers and sisters *(step brothers and sisters or foster brothers and sisters)*?

SECTION B SCHOOL

Now I'm going to ask you a few questions about school.

(B1)

Very much	Quite a bit	A little	Not very much	I hate school
0	1	2	3	4

B1	How do you feel about school? "I like school …."	How much do you like school?

(B2)

Very well	Well	Average	Poorly	Very poorly
0	1	2	3	4

B2. How well do you think you are doing in your school work?

(B3-B10)

All the time	Most of the time	Some of the time	Rarely	Never
0	1	2	3	4

B3. I feel safe **at** school.

B4. I feel safe on my way **to** and **from** school.

B5. My teacher treats me fairly.

B6.	If I have problems at school, my parents are ready to help.	My parents are ready to help me if I have problems at school.

B7. My parents encourage me to do well at school.

B8.	My parents expect too much of me at school.	My parents expect me to do better than I am able to do at school.

B9. I have a place at home to do homework or study.

B10. When my teacher gives me homework, I do it.

Section C ABOUT ME

Now I'm going to ask you a few questions about you.

(C1)

False	Mostly false	Sometimes	Mostly true	True
0	1	2	3	4

C1.

a. In general, I like the way I am.
b. Overall, I have a lot to be proud of.
c. A lot of things about me are good.
d. When I do something, I do it well.

SECTION D FEELINGS AND BEHAVIORS

Now I'm going to ask you a few questions about how you feel and act.

(D1)

Never or not true	Sometimes or somewhat true	Often or very true
1	2	3

D1.

a. I show sympathy to (feel sorry for) someone who has made a mistake.
b. I can't sit still, am restless or hyperactive.
c. I destroy my own things.
d. I will try to help someone who has been hurt.
e. I steal at home
f. I am unhappy, sad or depressed.
g. I get into many fights.

h.	I volunteer to help clear up a mess someone else has made.	I offer to help clean up a mess that somebody else has made.

i. I am distractible, have trouble sticking to any activity.

j.	I try when I am mad at someone, to get others to dislike him/her.	When I am mad at someone, I try to get other people to not like him/her.

k. I am not as happy as other people my age.

l.	I destroy things belonging to my family or other kids.	I destroy or wreck things that belong to my family or other kids.

Never or not true	Sometimes or somewhat true	Often or very true
_1	2	3_

m.	I will try, if there is a argument, to stop it	If there is an argument, I will try to stop it.

n. I fidget.

o.	I am disobedient at school.	I do not do what I am told to do at school.

p.	I can't concentrate, can't pay attention.	I have a hard time concentrating or paying attention.

q.	I am too fearful or anxious.	I am too afraid or nervous about things.

r.	When I am mad at someone, I become friends with another as revenge.	When I am mad at someone, I make friends with someone else to get back at them.

s. I am impulsive, act without thinking.
t. I tell lies or cheat.

u.	I offer to help other kids (*friend, brother or sister*) who are having difficulty with a task.	I offer to help other kids who are having trouble doing something.

v. I am worried.

w.	I have difficulty awaiting my turn in games or groups.	I have a hard time waiting for my turn in games or groups.

x. I assume, when another kid accidentally hurts me (such as bumping into me), that the other kid meant to do it, and then I react with anger and fighting.
y. I tend to do things on my own – am rather solitary.
z. When mad at someone, I say bad things behind his/her back.

aa.	I comfort a friend, brother or sister who is crying or upset.	I comfort other kids when they are crying or upset.

bb. I cry a lot.
cc. I give up easily

Never or not true	Sometimes or somewhat true	Often or very true
1	2	3

dd. I threaten people.

ee.	I help to pick up objects which another kid has dropped (*e.g. pencils, books*).	I help to pick up things that other kids have dropped (*e.g. pencils, books*).

ff.	I cannot settle to anything for more than a few moments.	I cannot focus on things for more than a few minutes.

gg. I feel miserable, unhappy, tearful, or distressed.
hh. I am cruel, bully, or am mean to others.
ii. I stare into space.

jj.	When mad at someone, I say to others: let's not be with him/her.	When I am mad at someone, I say to others: Let's not play with him or her.

kk. I am nervous, high-strung or tense.
ll. I kick, bite, hit other people my age.
mm. I will invite bystanders (EXPLAIN TERM IF NECESSARY) to join in a game.
nn. I steal outside the home.

oo.	I am inattentive, have difficulty paying attention to someone.	I have difficulty paying attention to someone.

pp. I have trouble enjoying myself.
qq. I help other people my age (*friends, brother, sister*) who are feeling sick.

rr.	When mad at someone, I tell the other one's secrets to a third person.	When I'm made at people, I tell their secrets to other people.

ss.	I take the opportunity to show support for the work of other people my age who can't do things as well as me.	I tell other kids who can't do things as well as I can that I like what they are doing or that they are doing well.

SECTION E MY PARENTS AND ME

Now I'm going to ask you a few questions about your parents and you.

(E1)

Never	Rarely or Hardly ever	Sometimes	Often	Always
0	1	2	3	4

E1. My parents (*or step parents or foster parents)* ...

a. smile at me.
b. want to know exactly where I am and what I am doing.
c. soon (*quickly*) forget a rule they have made.
d. praise me
e. let me go out any evening I want.
f. tell me what time to be home when I go out.

g.	nag me about little things.	bug me about things that are not important.

h. listen to my ideas and opinions
i and I solve a problem together whenever we disagree about something.

j.	only keep rules when it suits them.	only stick to the rules they make when they feel like it.

k. make sure I know I am appreciated.

l.	Threaten punishment more often than they use it.	Threaten to punish me more often than they really do it.

m. speak of (*talk about*) the good things I do.

n.	Find out about my misbehavior	Find out when I do something I'm not supposed to do.

o. enforce a rule or do not enforce a rule depending upon their mood (EXPLAIN TERM IF NECESSARY).
p. hit me or threaten to do so.
q. Seem proud of the things I do.

SECTION F ACTIVITIES

Now I'm going to ask you a few questions about the things you do in your spare time.

(H1)

Never	Less than once a week	2 or 3 times a week	4 or more times a week
1	2	3	4

F1. In the last 4 months, how often have you …

a. played sports or done physical activities **without** a coach or instructor (biking, skateboarding etc.)?
b. played sports **with** a coach or instructor, other than in gym class (school teams, swimming lessons etc.)?

c.	taken part in dance, gymnastics or cheerleading groups or lessons, other than in gym class?	taken part in dance or gymnastics outside of gym class? Was it lessons or in a club?

d.	taken part in art, drama or music groups, clubs or lessons outside of class?	taken part in art, drama or music outside of class? Was it lessons or in a club?

e.	taken part in clubs or groups such as Guides or Scouts, 4-H club, community, church or other religious groups?	taken part in Guides or Scouts, community groups, or church groups?

f. had a job (a paper route, babysitting, etc.)?
g. played computer or video games?
h. Watched TV?

(H2)

None	1 to 2 hours a day	3 or 4 hours a day	5 to 6 hours a day	7 or more hours a day
0	1	2	3	4

F2. On average, about how many hours a day do you watch TV?

(H3)

Every day	a few times a week	Once a week	a few times a month	Less than once a month	Almost never
0	1	2	3	4	5

F3. How often do you read for fun (not for school)?

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COPE CHILD QUESTIONNAIRE #3

I spoke with you, or someone like me from our team, spoke with you about 4 months ago. Do you remember that meeting? Yes No

> If "yes", proceed.
>
> If "no": Well, about 4 months ago, we came to your school and asked you to come out of class and answer a whole bunch of questions. In that interview, we asked you some questions about your family and friends, about how you felt about things and about what you liked to do. This time, I will ask you some questions like that again to see how you think and feel about those things now.

Your answers will help in our study of the needs of children in the Calgary school system.

This is not a test and there are **no right or wrong answers**.

Some questions may seem personal and some are about things which not everybody does.

Take your time and please be sure to answer each question based on what you really think.

You can choose whether or not to fill out this questionnaire. If you need help with any questions, you may ask the interviewer.

SECTION 0

First I'd like to ask you about things you (may) have done since the last interview.

(STUDY-GROUP ONLY):

1. We understand that you've met with a doctor or a group of doctors at your school:
    a. How many times did you meet with the doctor(s) at the school?
    b. Do you know why you met with them?
    c. What happened at the meeting(s)?
    d. What did you learn from the doctor(s)?
    e. Are things any better for you or worse for you since you first saw the doctor(s) at school? (Prompt: In what ways)
2. Have you met with anyone else to talk about the same things as you talked about with the doctor(s)?
    a. Do you know who that person was?
    b. Do you know why you met with them?
    c. What happened at that meeting?
    d. Did you learn anything from them?
    e. Are things any better for you or worse for you since you first saw him/her? (Prompt: In what ways)
3. Did you meet with anyone else than (him/her) to talk about these things?
    a. Do you know who that person was?
    b. Do you know why you met with them?
    c. What happened at that meeting?
    d. Did you learn anything from them?
    e. Are things any better for you or worse for you since you first saw him/her? (Prompt: In what ways)

(CONTROL-GROUP ONLY)

1. Since the last time we asked you questions, have you talked with anyone at school (like your teacher or anyone else) since the about any problems you might be having at school or at home?

   a. Could you tell me about that?

   b. Was your mom or dad with you when you talked to them?

   c. What happened at that meeting?

   d. What did you learn from that meeting?

   e. Are things any better for you or worse for you since you talked with them at school? (Prompt: In what ways)

2. Have you met with anyone else at school or outside of school to talk about the same things as you talked about with the people at school?

   a. Do you know who that person was?

   b. Do you know why you met with them?

   c. What happened at that meeting?

   d. Did you learn anything from them?

   e. Are things any better for you or worse for you since you first saw him/her? (Prompt: In what ways)

SECTION A FRIENDS AND FAMILY

Now I'm going to ask you a few questions about your friends and family (introduce response set).

(A1-A4)

False	Mostly False	Sometimes	Mostly True	True
0	1	2	3	4

A1 I have a lot of friends.
A2 I get along with kids easily.
A3 Other kids want me to be their friend.
A4 Most other kids like me.

(A5)

Never	Less than once a week	1 day a a week	2 or 3 days a week	4 or 5 days a week	Everyday
0	1	2	3	4	5

A5	About how many days a week do you do things with friends outside of school hours?	How often do you do things with friends away from school?

A6 How many close friends do you have?

A7	Other than your friends, do you have anyone else in particular you can talk to about yourself or your problems?	Besides your friends, are there other people you can talk to about yourself or any problems you are having?

Yes (A8)

1. Mother
2. Father
3. Stepmother
4. Stepfather
5. Brother
6. Sister
7. Grandparent
8. Other relative
9. A friend of the family
10. Sitter or babysitter
11. Parent's boyfriend/girlfriend
12. Teacher
13. Coach or leader
14. Other

No

No Contact	No problems	Hardly any problems	Problems once in a while	Frequent problems	Constant Problems
0	1	2	3	4	5

A9. During the last 4 months, how well have you gotten along with your friends or classmates?

A10. During the last 4 months, how well have you gotten along with your mother *(step mother or foster mother)*?

A11. During the last 4 months, how well have you gotten along with your father *(step father or foster father)*?

A12. During the last 4 months, how well have you gotten along with your brothers and sisters *(step brothers and sisters or foster brothers and sisters)*?

SECTION B SCHOOL

Now I'm going to ask you a few questions about school.

(B1)

Very much	Quite a bit	A little	Not very much	I hate school
0	1	2	3	4

B1	How do you feel about school? "I like school ...."	How much do you like school?

(B2)

Very well	Well	Average	Poorly	Very poorly
0	1	2	3	4

B2. How well do you think you are doing in your school work?

(B3-B10)

All the time	Most of the time	Some of the time	Rarely	Never
0	1	2	3	4

B3. I feel safe **at** school.

B4. I feel safe on my way **to** and **from** school.

B5. My teacher treats me fairly.

B6.	If I have problems at school, my parents are ready to help.	My parents are ready to help me if I have problems at school.

B7. My parents encourage me to do well at school.

B8.	My parents expect too much of me at school.	My parents expect me to do better than I am able to do at school.

B9. I have a place at home to do homework or study.

B10. When my teacher gives me homework, I do it.

Section C ABOUT ME

Now I'm going to ask you a few questions about you.

(C1)

False	Mostly false	Sometimes	Mostly true	True
0	1	2	3	4

C1.

a. In general, I like the way I am.
b. Overall, I have a lot to be proud of.
c. A lot of things about me are good.
d. When I do something, I do it well.

SECTION D FEELINGS AND BEHAVIORS

Now I'm going to ask you a few questions about how you feel and act.

(D1)

Never or not true	Sometimes or somewhat true	Often or very true
1	2	3

D1.

a. I show sympathy to (feel sorry for) someone who has made a mistake.
b. I can't sit still, am restless or hyperactive.
c. I destroy my own things.
d. I will try to help someone who has been hurt.
e. I steal at home
f. I am unhappy, sad or depressed.
g. I get into many fights.

h.	I volunteer to help clear up a mess someone else has made.	I offer to help clean up a mess that somebody else has made.

i. I am distractible, have trouble sticking to any activity.

j.	I try when I am mad at someone, to get others to dislike him/her.	When I am mad at someone, I try to get other people to not like him/her.

k. I am not as happy as other people my age.

l.	I destroy things belonging to my family or other kids.	I destroy or wreck things that belong to my family or other kids.

Never or not true	Sometimes or somewhat true	Often or very true
_1	2	3_

m.	I will try, if there is a argument, to stop it	If there is an argument, I will try to stop it.

n. I fidget.

o.	I am disobedient at school.	I do not do what I am told to do at school.

p.	I can't concentrate, can't pay attention.	I have a hard time concentrating or paying attention.

q.	I am too fearful or anxious.	I am too afraid or nervous about things.

r.	When I am mad at someone, I become friends with another as revenge.	When I am mad at someone, I make friends with someone else to get back at them.

s. I am impulsive, act without thinking.
t. I tell lies or cheat.

u.	I offer to help other kids (*friend, brother or sister*) who are having difficulty with a task.	I offer to help other kids who are having trouble doing something.

v. I am worried.

w.	I have difficulty awaiting my turn in games or groups.	I have a hard time waiting for my turn in games or groups.

x. I assume, when another kid accidentally hurts me (such as bumping into me), that the other kid meant to do it, and then I react with anger and fighting.
y. I tend to do things on my own – am rather solitary.
z. When mad at someone, I say bad things behind his/her back.

aa.	I comfort a friend, brother or sister who is crying or upset.	I comfort other kids when they are crying or upset.

bb. I cry a lot.
cc. I give up easily

Never or not true	Sometimes or somewhat true	Often or very true
_1	2	3_

dd. I threaten people.

ee.	I help to pick up objects which another kid has dropped (*e.g. pencils, books*).	I help to pick up things that other kids have dropped (*e.g. pencils, books*).

ff.	I cannot settle to anything for more than a few moments.	I cannot focus on things for more than a few minutes.

gg. I feel miserable, unhappy, tearful, or distressed.
hh. I am cruel, bully, or am mean to others.
ii. I stare into space.

jj.	When mad at someone, I say to others: let's not be with him/her.	When I am mad at someone, I say to others: Let's not play with him or her.

kk. I am nervous, high-strung or tense.
ll. I kick, bite, hit other people my age.
mm. I will invite bystanders (EXPLAIN TERM IF NECESSARY) to join in a game.
nn. I steal outside the home.

oo.	I am inattentive, have difficulty paying attention to someone.	I have difficulty paying attention to someone.

pp. I have trouble enjoying myself.
qq. I help other people my age (*friends, brother, sister*) who are feeling sick.

rr.	When mad at someone, I tell the other one's secrets to a third person.	When I'm made at people, I tell their secrets to other people.

ss.	I take the opportunity to show support for the work of other people my age who can't do things as well as me.	I tell other kids who can't do things as well as I can that I like what they are doing or that they are doing well.

SECTION E MY PARENTS AND ME

Now I'm going to ask you a few questions about your parents and you.

(E1)

Never	Rarely or Hardly ever	Sometimes	Often	Always
0	1	2	3	4

E1. My parents (*or step parents or foster parents)* ...

a. smile at me.
b. want to know exactly where I am and what I am doing.
c. soon (*quickly*) forget a rule they have made.
d. praise me
e. let me go out any evening I want.
f. tell me what time to be home when I go out.

g.	nag me about little things.	bug me about things that are not important.

h. listen to my ideas and opinions
i and I solve a problem together whenever we disagree about something.

j.	only keep rules when it suits them.	only stick to the rules they make when they feel like it.

k. make sure I know I am appreciated.

l.	Threaten punishment more often than they use it.	Threaten to punish me more often than they really do it.

m. speak of (*talk about*) the good things I do.

n.	Find out about my misbehavior	Find out when I do something I'm not supposed to do.

o. enforce a rule or do not enforce a rule depending upon their mood (EXPLAIN TERM IF NECESSARY).
p. hit me or threaten to do so.
q. Seem proud of the things I do.

SECTION F ACTIVITIES

Now I'm going to ask you a few questions about the things you do in your spare time.

(H1)

Never	Less than once a week	2 or 3 times a week	4 or more times a week
1	2	3	4

F1. In the last 4 months, how often have you …

a. played sports or done physical activities **without** a coach or instructor (biking, skateboarding etc.)?
b. played sports **with** a coach or instructor, other than in gym class (school teams, swimming lessons etc.)?

c.	taken part in dance, gymnastics or cheerleading groups or lessons, other than in gym class?	taken part in dance or gymnastics outside of gym class? Was it lessons or in a club?

d.	taken part in art, drama or music groups, clubs or lessons outside of class?	taken part in art, drama or music outside of class? Was it lessons or in a club?

e.	taken part in clubs or groups such as Guides or Scouts, 4-H club, community, church or other religious groups?	taken part in Guides or Scouts, community groups, or church groups?

f. had a job (a paper route, babysitting, etc.)?
g. played computer or video games?
h. Watched TV?

(H2)

None	1 to 2 hours a day	3 or 4 hours a day	5 to 6 hours a day	7 or more hours a day
0	1	2	3	4

F2. On average, about how many hours a day do you watch TV?

(H3)

Every day	a few times a week	Once a week	a few times a month	Less than once a month	Almost never
0	1	2	3	4	5

F3. How often do you read for fun (not for school)?

Appendix C Educator Surveys

Contents:

1. CLC Specialist Survey C-1
2. Principal Survey C-5
3. Teacher Survey
    - Part A C-10
    - Part B C-35

Questionnaire to CLC Specialists

This questionnaire is being administered to CLC Specialists involved in the Community Outreach in Pediatrics/Psychiatry in Education (COPE) research program during the 1998-99 school year. The research program covers schools in the intervention group, and in two control groups. We would ask that you complete this questionnaire, and sign the accompanying consent form, and return both to us at: COPE, c/o Calgary Board of Education, Parkdale Centre, 728 – 32 Street N.W., Calgary, AB T2N 2V9 by January 15, 1999. If you wish to elaborate further on any of the questions, please feel free to attach additional pages.

Name of CLC: ____________________

Name of Person Completing Questionnaire: ____________________

1. What is the process for identifying students with emotional, behavioural and/or learning problems for discussion at School Resources Group (SRG) meetings in your CLC? That is, what triggers the decision to bring a case to the SRG?

2. Does your CLC employ particular strategies for identifying children with emotional, behavioural and/or learning difficulties for discussion at SRG meetings?

3. Who is present at the SRG meetings at the schools in your CLC? Are particular staff positions (Instructional Resource Person, Principal, CLC Specialist, etc.) always, or normally present, and if so which positions are these?

C-1

4. Is there a typical or standard procedure followed at SRG meetings when discussing a case? If so, please describe this procedure. If no standard procedure is used, please describe the way in which the SRG meetings are conducted.

5. At the SRG meetings, what are the key determinants used to identify the need for further assessment of students as having the following problems: (i.e., what kinds of data are used to make decisions?)

   A. Emotional problems

   B. Learning difficulties

   C. Behavioral problems

6. What procedure/protocol does the SRG follow in making recommendations? Please describe the way in which the SRG may make a decision to recommend further assessment of the child.

7. Please describe the ways (if any) in which the student is involved in the process of identifying emotional, behavioural and/or learning difficulties, and in developing a school-based response?

8. Please describe the ways (if any) in which the parent(s)/caregivers are involved in the process of identifying emotional, behavioural and/or learning difficulties, and in developing a school-based response?

9. How are decisions and recommendations of the SRG communicated to parents?

10. What strategy is followed in your CLC in monitoring the implementation of the recommendations of the SRG?

11. Please describe the role of the CLC specialists in your CLC (i.e., yourself and your colleagues) in identifying children with emotional, behavioural and/or learning difficulties, and in developing a school-based response.

12. Please describe the type of services available to educators and families in Calgary for the identification and treatment of students with emotional, behavioural and/or learning difficulties.

13. Please comment on the extent to which such services are readily available to the students who require them?

14. What mechanisms are used in your CLC to track students' access to appropriate remedial services? (i.e. Do you track processes such as time between identification and referral , and time between referral and access to services? If so, please describe the way in which you track such services.)

*****

Thank you for taking the time to complete this questionnaire. Please return this in the envelope provided, together with a signed copy of the consent form, by January 15, 1999.

Questionnaire to School Principals

This questionnaire is being administered to Principals of schools involved in the Community Outreach in Pediatrics/Psychiatry in Education (COPE) research program during the 1998-99 school year. The research program covers schools in the intervention group, and in two control groups. We would ask that you complete this questionnaire, and sign the accompanying consent form, and return both to us at: COPE, c/o Calgary Board of Education, Parkdale Centre, 728 – 32 Street N.W., Calgary, AB T2N 2V9 by January 15, 1999. If you wish to elaborate further on any of the questions, please feel free to attach additional pages.

Name of School: ______________________________

Name of Person Completing Questionnaire: ______________________________

1. What is the process for identifying students with emotional, behavioural and/or learning problems for discussion at School Resources Group (SRG) meetings in your school? That is, what triggers the decision to bring a case to the SRG?

2. Does your school employ particular strategies for identifying children with emotional, behavioural and/or learning difficulties for discussion at SRG meetings?

3. Who is present at the SRG meetings in your school? Are particular staff positions (Instructional Resource Person, Principal, CLC Specialist, etc.) always, or normally present, and if so which positions are these?

4. Is there a typical or standard procedure followed at SRG meetings when discussing a case? If so, please describe this procedure. If no standard procedure is used, please describe the way in which the SRG meetings are conducted.

5. At the SRG meetings, what are the key determinants used to identify the need for further assessment of students as having the following problems: (i.e., what kinds of data are used to make decisions?)

   A. Emotional problems

   B. Learning difficulties

   C. Behavioral problems

6. What procedure/protocol does the SRG follow in making recommendations? Please describe the way in which the SRG may make a decision to recommend further assessment of the child.

7. Please describe the ways (if any) in which the student is involved in the process of identifying emotional, behavioural and/or learning difficulties, and in developing a school-based response?

8. Please describe the ways (if any) in which the parent(s)/caregivers are involved in the process of identifying emotional, behavioural and/or learning difficulties, and in developing a school-based response?

9. How are decisions and recommendations of the SRG communicated to parents?

10. What strategy is followed at your school in monitoring the implementation of the recommendations of the SRG?

11. Please describe the role of the CLC specialists responsible for your school in identifying children with emotional, behavioural and/or learning difficulties, and in developing a school-based response.

12. Please describe the type of services available to educators and families in Calgary for the identification and treatment of students with emotional, behavioural and/or learning difficulties.

13. Please comment on the extent to which such services are readily available to the students who require them?

14. What mechanisms are used in your school to track students' access to appropriate remedial services? (i.e. Do you track processes such as time between identification and referral , and time between referral and access to services? If so, please describe the way in which you track such services.)

*****

Thank you for taking the time to complete this questionnaire. Please return this in the envelope provided, together with a signed copy of the consent form, by January 15, 1999.

C.O.P.E.
Community Outreach in Pediatrics/Psychiatry and Education
Parkdale Centre, 728 - 32 St. N.W.
Calgary, Alberta, Canada
T2N 2V9

C.O.P.E. Teacher Survey

To be completed by the classroom teacher of ________________

Instructions:

The purpose of this survey is to gather information on various school factors which may influence the development and education of children. The items in this questionnaire relate to a particular student in your class, to various school practices, and to yourself.

Please complete PART A (Sections 0 to 3) for the particular student in your class named above and complete PART B (Section 4 to 6) ONLY ONCE for your school practices and yourself.

Completion of the questionnaire is completely voluntary. However, to ensure that we have a complete picture of all the forces which shape this student's development, we strongly encourage you to complete the questionnaire within the next five days.

Please complete the enclosed Educator's Consent Form to indicate your willingness to participate in this research.

We would be most happy to answer any questions you might have. Please feel free to call. The telephone number for the C.O.P.E. program is 777-7240 ext. 2239.

When you finish this survey:

Please place the completed questionnaire and the Consent Form in the reply envelope and send it directly to us today through the CBE mail system.

Thank you for your cooperation.

C-9

C.O.P.E. Teacher Survey PART A

SECTION 0 General Information

DATE: ____________________

1. Your name: ________________________
2. Child's name: ________________________
3. Your relationship to the child: ________________________
4. If you had to describe in your own words the problems this child has, how would you describe them?

____

____

____

5. If you had to describe in your own words the gifts or strengths that this child has, how would you describe them?

____

____

____

6. In question #1, you described the problems this child experiences.

    a) when did this behavior become a problem at his/her school?

____

____

____

b) how would you describe the school's response to this child's problem?

____

____

____

c) how satisfied are you with the response this child has gotten from the school to date? (Circle One)

1. very satisfied
2. somewhat satisfied
3. not very satisfied
4. not at all satisfied

d) Is there something that the school and/or other professionals should be doing for this child that they are not doing? Please elaborate.

____

____

____

7. Please describe the ways (if any) in which you have been involved in identifying emotional, behavioral and/or learning problems with this child, and in developing a response along with the parent and other school professionals.

____

____

____

8. How have decisions about this child's emotional, behavioral or learning problems at school been communicated to you?

____

____

____

9. How have decisions about this child's emotional, behavioral or learning problems at home been communicated to you?

____

____

____

10. What types of services are you aware of in Calgary that are available to families who have children with emotional, behavioral and/or learning problems?

____

____

____

11. During the 12 month period prior to contact with COPE ...

a) what community-based resources ...

i) have been initiated by the school for this child?

____

____

____

____

ii) have been recommended by the school to the child's parent(s)?

____

____

____

____

b) what school-based resources ...

i) have been initiated by the school for this child?

____

____

____

____

ii) have been recommended by the school to the child's parent(s)?

____

____

____

____

c) what medically-based resources …

i) have been initiated by the school for this child?

ii) have been recommended by the school to the child's parent(s)?

12. Follow-through on the initiations or recommendations for …

a) Was there follow-through on the initiations or recommendations for **community-based resources**? yes no

if "yes", **how helpful** were the resources to this child?

Very helpful Somewhat helpful Not very helpful Not at all helpful

If "no", what were the most significant factors preventing follow-through?

1) lack of parental follow-through due to
    a) financial constraints
    b) limited logistical capability
    c) limited knowledge of the resource
    d) disagreement with the initiation or recommendation
    e) other, please describe

2) lack of access to the resource due to
    a) waiting period
    b) refusal by the agency/resource, please describe reasons if known:
    c) other, please describe

____

____

____

____

3) lack of capacity of the school to pursue or monitor due to
    a) financial constraints
    b) limited logistical capability
    c) limited knowledge of the resource
    d) limited time and staff
    e) other, please describe

____

____

____

____

b) Was there follow-through on the initiations or recommendations for **school-based resources**? yes no

if "yes", **how helpful** were the resources to this child?

Very helpful Somewhat helpful Not very helpful Not at all helpful

If "no", what were the most significant factors preventing follow-through?

1) lack of parental follow-through due to
    a) financial constraints
    b) limited logistical capability
    c) limited knowledge of the resource
    d) disagreement with the initiation or recommendation
    e) other, please describe

____

____

____

____

2) lack of access to the resource due to
    a) waiting period
    b) refusal by the agency/resource, please describe reasons if known:

____

____

____

____

    c) other, please describe

3) lack of capacity of the school to pursue or monitor due to
    a) financial constraints
    b) limited logistical capability
    c) limited knowledge of the resource
    d) limited time and staff
    e) other, please describe

c) Was there follow-through on the initiations or recommendations for **medically-based resources**? yes no

if "yes", **how helpful** were the resources to this child?

Very helpful Somewhat helpful Not very helpful Not at all helpful

If "no", what were the most significant factors preventing follow-through?

1) lack of parental follow-through due to
    a) financial constraints
    b) limited logistical capability
    c) limited knowledge of the resource
    d) disagreement with the initiation or recommendation
    e) other, please describe

2) lack of access to the resource due to
    a) waiting period
    b) refusal by the agency/resource, please describe reasons if known:
    c) other, please describe

3) lack of capacity of the school to pursue or monitor due to
   a) financial constraints
   b) limited logistical capability
   c) limited knowledge of the resource
   d) limited time and staff
   e) other, please describe

13. What would the primary reasons be for referring this for COPE intervention?

SECTION 1 This student's education

The following sections relate to the educational development of a specific student in your class.

Please mark only one response box ☒ per question unless otherwise indicated.

These first few questions ask about this student's grade and educational history.

1

Is this student in a split or multi-grade class?

☐ Yes → What grades are contained in this class? grade ☐ to grade ☐

☐ No, the class contains a single grade

☐ No, the class is ungraded

2

Is this student assigned to a grade?

☐ Yes → In what grade is this student? grade ☐

☐ No, this student is not assigned to a grade

3

Is this student currently repeating his or her grade?

☐ Yes

☐ No

C-17

4

How would you rate this student's current academic achievement in non-written communication (e.g., comprehension, oral communication and oral presentation)?
(If you don't feel confident evaluating this student in non-written communication, please ask the appropriate teacher without showing her/him this questionnaire to other individuals.)

☐ Near the top of the class

☐ Above the middle of the class, but not at the top

☐ In the middle of the class

☐ Below the middle of the class, but above the bottom

☐ Near the bottom of the class

☐ Unable to get the appropriate evaluation

5

How would you rate this student's current academic achievement in written work (e.g., grammar and composition)?
(If you don't feel confident evaluating this student in written work, please ask the appropriate teacher without showing her/him this questionnaire. The information you are providing is confidential. Please refrain from showing this questionnaire to other individuals.)

☐ Near the top of the class

☐ Above the middle of the class, but not at the top

☐ In the middle of the class

☐ Below the middle of the class, but above the bottom

☐ Near the bottom of the class

☐ Unable to get the appropriate evaluation

6

How would you rate this student's current academic achievement in mathematics?
(If you don't feel confident evaluating this student in math, please ask the appropriate teacher without showing her/him this questionnaire. The information you are providing is confidential. Please refrin from showing this questionnaire to other individuals.)

- ☐ Near the top of the class
- ☐ Above the middle of the class, but not at the top
- ☐ In the middle of the class
- ☐ Below the middle of the class, but above the bottom
- ☐ Near the bottom of the class
- ☐ Unable to get the appropriate evaluation

7

How would you rate this student's current academic achievement in sciences (e.g., chemistry, physics,etc.)?
(If you don't feel confident evaluating this student in sciences, please ask the appropriate teacher without showing him/her this questionnaire. The information you are providing is confidential. Please refrain from showing this questionnaire to other individuals.)

- ☐ Near the top of the class
- ☐ Above the middle of the class, but not at the top
- ☐ In the middle of the class
- ☐ Below the middle of the class, but above the bottom
- ☐ Near the bottom of the class
- ☐ Unable to get the appropriate evaluation

8

How would you rate this student's current academic achievement across all areas of instruction?
(If you don't feel confident evaluating this student across all areas of instruction, please ask the appropriate teachers without showing them this questionnaire. The information you are providing is confidential. Please refrain from showing this questionnaire to other indviduals.)

☐ Near the top of the class

☐ Above the middle of the class, but not at the top

☐ In the middle of the class

☐ Below the middle of the class, but above the bottom

☐ Near the bottom of the class

☐ Unable to get the appropriate evaluation

9

Looking ahead, how far do you expect this student will go in school? Will he/she..........

☐ Complete some secondary or high school?

☐ Graduate from secondary or high school?

☐ Learn a trade (e.g., through apprenticeship)

☐ Obtain a community college, technical college, vocational college, business school, or CEGEP certificate or diploma?

☐ Obtain a university degree?

☐ Don't know

The following questions ask about this student's academic and educational strengths and weaknesses.

10

Does this student receive enhanced or extra instruction at school because of exceptionally advanced intellectual, athletic or artistic abilities?

☐ Yes

☐ No ➜ **GO TO QUESTION 12**

11

Where does this student receive this enhanced or extra instruction?

☐ Exclusively within regular classrooms with existing resources

☐ Exclusively within a regular classroom with a special aide/assistant teacher

☐ Primarily within regular classrooms but with some time spent in special education classes or resource rooms

☐ Exclusively or primarily within special education classes or resource rooms within a regular school

☐ Exclusively or primarily within a specialized school

☐ Other

12

Does this student receive additional help (e.g. remedial) because he/she is weak in certain subjects or skills?

☐ Yes

☐ No

☐ Don't know

13

Does this student receive special/resource help because a learning disability, a physical, emotional, behavioral, or other problem limits the kind or amount of school work she/he can do?

☐ Yes

☐ No
} **GO TO QUESTION 16**
☐ Don't know

14

What type of problem limits this student's ability to do school work in a regular classroom? (*Mark all that apply)*

☐ Physical disability

☐ Visual impairment

☐ Hearing impairment

☐ Speech impairment

☐ Learning disability

☐ Emotional or behavioral problem

☐ Mental disability or limitation

☐ Home environment/problems at home

☐ Problems understanding the language spoken at school

☐ Other, please specify

15

Where does this student receive this special/resource help (e.g., special education)?

☐ Exclusively within regular classrooms with existing resources

☐ Exclusively within regular classrooms with a special aide/assistant teacher

☐ Primarily within regular classrooms but with some time spent in special education classes or resource rooms

☐ Exclusively or primarily within special education classes or resource rooms within a regular school

☐ Exclusively or primarily within a specialized school

☐ Other

SECTION 2 This student's behavior and attendance

The first two questions in this section concern attendance.

16

On average per month, how many days has this child been absent this school year?

☐ 0 days

☐ 1 – 3 days

☐ 4 – 6 days

☐ 7 - 10 days

☐ 11 – 20 days

☐ More than 20 days

17

Since the beginning of school in the fall, approximately how many times has this student skipped your class (was absent without a valid reason)?

☐ Never

☐ Once or twice

☐ Three to five times

☐ Six to ten times

☐ More than ten times

☐ Don't know

18

Since the start of school in the fall, how often has this student arrived:

	Never	Rarely	Some-times	Usually	Always	N/A	Don't know
a) without the materials to do his/her schoolwork (e.g., notebooks, paper)	☐	☐	☐	☐	☐	☐	☐
b) inadequately clothed to participate in school related activities (e.g., gym, sports, field trips, recess)	☐	☐	☐	☐	☐	☐	☐
c) inadequately dressed for the weather conditions	☐	☐	☐	☐	☐	☐	☐
d) too tired to do school work	☐	☐	☐	☐	☐	☐	☐
e) without his/her homework completed	☐	☐	☐	☐	☐	☐	☐
f) late for school	☐	☐	☐	☐	☐	☐	☐
g) without proper nourishment	☐	☐	☐	☐	☐	☐	☐

19

Using the answers "never or not true", "sometimes or somewhat true", and "often or very true", how often would you say that this student....

		Never or Not True	Sometimes or Somewhat True	Often or Very True	Don't Know
a)	shows sympathy to someone who has made a mistake	☐	☐	☐	☐
b)	can't sit still, is restless or hyperactive	☐	☐	☐	☐
c)	destroys his/her own things	☐	☐	☐	☐
d)	will try to help someone who has been hurt	☐	☐	☐	☐
e)	steals	☐	☐	☐	☐
f)	seems to be unhappy, sad or depressed	☐	☐	☐	☐
g)	gets into many fights	☐	☐	☐	☐
h)	volunteers to help clear up a mess someone else has made	☐	☐	☐	☐
i)	is distractible, has trouble sticking to any activity	☐	☐	☐	☐
j)	when angry with someone tries to get others to dislike her/him	☐	☐	☐	☐
k)	is not as happy as other students	☐	☐	☐	☐
l)	destroys things belonging to others	☐	☐	☐	☐

	Never or Not True	Sometimes or Somewhat True	Often or Very True	Don t Know
m) if there is a quarrel or dispute will try to stop it	☐	☐	☐	☐
n) fidgets	☐	☐	☐	☐
o) is disobedient at school	☐	☐	☐	☐
p) can't concentrate, can't pay attention for long	☐	☐	☐	☐
q) is usually fearful or anxious	☐	☐	☐	☐
r) when angry with someone becomes friends with another for revenge	☐	☐	☐	☐
s) is impulsive, acts without thinking	☐	☐	☐	☐
t) tells lies or cheats	☐	☐	☐	☐
u) offers to help other children/youths (friend, brother, sister) who are having difficulty with a task	☐	☐	☐	☐
v) is worried	☐	☐	☐	☐
w) has difficulty awaiting turn in games or groups	☐	☐	☐	☐
x) when another individual accidentally hurts him/her (such as by bumping into her/him), assumes that the other youth meant to do it, and reacts with anger and fighting	☐	☐	☐	☐

	Never or Not True	Sometimes or Somewhat True	Often or Very True	Doh t Know
y) tends to do things on his/her own is rather solitary	☐	☐	☐	☐
z) when angry with someone says bad things behind the other's back	☐	☐	☐	☐
aa) physically attacks people	☐	☐	☐	☐
bb) comforts others (friend, brother, sister), who is crying or upset	☐	☐	☐	☐
cc) cries a lot	☐	☐	☐	☐
dd) vandalizes	☐	☐	☐	☐
ee) gives up easily	☐	☐	☐	☐
ff) threatens people	☐	☐	☐	☐
gg) spontaneously helps to pick up objects which another child/youth has dropped (e.g., pencils, books)	☐	☐	☐	☐
hh) cannot settle to anything for more than a few minutes	☐	☐	☐	☐
ii) appears miserable, unhappy, tearful, distressed	☐	☐	☐	☐
jj) is cruel, bullies or is mean to others	☐	☐	☐	☐
kk) stares into space	☐	☐	☐	☐

	Never or Not True	Sometimes or Somewhat True	Often or Very True	Don't Know
ll) when angry with someone, says to others; "let's not be with her/him"	☐	☐	☐	☐
mm) is nervous, high-strung or tense	☐	☐	☐	☐
nn) kicks, bites, hits other students	☐	☐	☐	☐
oo) will invite bystanders to join in a game	☐	☐	☐	☐
pp) is inattentive	☐	☐	☐	☐
qq) has trouble enjoying self	☐	☐	☐	☐
rr) helps others (friends, brother or sister) who are feeling sick	☐	☐	☐	☐
ss) When angry with someone , tells the other one's secrets to a third person	☐	☐	☐	☐
tt) Takes the opportunity to praise the work of less able children/youths	☐	☐	☐	☐

20

Listed below are various social and personal skills. Please indicate how often this student demonstrates each of the following:

	Never	Rarely	Sometimes	Usually	Always
a) works cooperatively with other students	☐	☐	☐	☐	☐
b) interacts socially with other students	☐	☐	☐	☐	☐
c) Follows rules	☐	☐	☐	☐	☐
d) follows instructions	☐	☐	☐	☐	☐
e) respects the property of others	☐	☐	☐	☐	☐
f) demonstrates self control	☐	☐	☐	☐	☐
g) shows self-confidence	☐	☐	☐	☐	☐
h) demonstrates respect for adults	☐	☐	☐	☐	☐
i) demonstrates respect for other youth	☐	☐	☐	☐	☐
j) accepts responsibility for actions	☐	☐	☐	☐	☐

21

These statements describe work habits. Please indicate how often this student demonstrates each of these work habits:

	Never	Rarely	Sometimes	Usually	Always
a) listens attentively	☐	☐	☐	☐	☐
b) follows directions	☐	☐	☐	☐	☐
c) completes work on time	☐	☐	☐	☐	☐
d) works independently	☐	☐	☐	☐	☐
e) takes care of materials	☐	☐	☐	☐	☐
f) works neatly and carefully	☐	☐	☐	☐	☐

22

Does this student have special skills or talents in any of the following areas?

	Yes	No	Don't Know
a) sports or athletics	☐	☐	☐
b) academic work (e.g., numeracy or literacy skills)	☐	☐	☐
c) arts	☐	☐	☐
d) music	☐	☐	☐
e) technical skills (e.g. computer skills)	☐	☐	☐
f) interpersonal skills (e.g. leadership skills)	☐	☐	☐
g) other skills (please specify)	☐	☐	☐

SECTION 3 Involvement of Parent(s) and Guardian(s)

These next questions concern your impressions of how involved parent(s) and/or guardian(s) is(are) with this student's education. This information will enable us to determine whether such involvement helps or hinders the student's academic achievement and development.

23

Since the beginning of school last fall did a parent/guardian of this student....

	Yes	No	Not Applicable
a) participate in regularly scheduled parent-teacher conferences (either in person or on the telephone)	☐	☐	☐
b) contact you to discuss this student's academic performance or behavior	☐	☐	☐
c) return your call to talk about this student's academic performance or behavior	☐	☐	☐
d) correspond with you in writing regarding this student's academic performance or behavior (e.g., through the student's agenda or planner)	☐	☐	☐
e) volunteer in our class	☐	☐	☐
f) correspond with you regarding this student's academic performance or behavior in a manner not listed above (Please specify)	☐	☐	☐

24

In your opinion, how involved is(are) the parent(s)/guardian(s) in this student's education?

- ☐ Very involved
- ☐ Somewhat involved
- ☐ Not involved
- ☐ Don't Know the parent(s)/guardian(s) well enough

25

In your opinion, how important is school to these parents/guardians that this student receives good grades in school?

- ☐ Very important
- ☐ Somewhat important
- ☐ Of little importance
- ☐ Don't know the parent(s)/guardian(s) well enough

26

In your opinion, how strongly does (do) this student's parent(s)/guardian(s) support your teaching efforts?

- ☐ Strongly support
- ☐ Somewhat support
- ☐ Do/does not support
- ☐ Don't know the parent(s)/guardian(s) well enough

Once completed this questionnaire is confidential. It should not be shown to any other person and should be directly returned to the COPE office.

Your contribution to this effort is greatly appreciated!

C.O.P.E. Teacher Survey: PART B

Completed by the classroom teacher of the following students involved with COPE:

_______________/_______________/_______________/_______________

SECTION 4 This student's Class and Your Teaching Practices

This information will help us understand how the classroom may affect students' academic and social functioning.

These first few questions gather information about the class(es) that you teach this student.

27

In the class(es) that you teach this student, on average, how many students are now enrolled?

☐ **Students**

28

Please estimate the average percentage of instruction time when a qualified teaching assistant (including student teachers, lab demonstrators) and/or an adult volunteer is (are) available in the class(es) that you teach this student.

	Average percentage of instruction time available				
	Not Available	1 to 25%	26 to 50%	51 to 75%	More than 75%
a) Qualified Teaching Assistant	☐	☐	☐	☐	☐
b) Adult Volunteer	☐	☐	☐	☐	☐

29

In the class(es) that you teach this student, how many students have any of the following long-term problems – whether or not the problem has been officially identified:
(Some students may belong to more than one category)

a) a speech, hearing, vision, mobility or other health impairment that affects their learning ☐ **Students**

b) an emotional or behavioral problem ☐ **Students**

c) a learning problem (e.g.: a problem with attention, memory, reasoning, reading, writing, spelling, or calculation which interferes with learning) ☐ **Students**

30

In the class(es) you teach this student on average how many students....
(Some students may belong to more than one category)

a) have a first language other than English or French? ☐ **Students**

b) arrived in Canada within the last year? ☐ **Students**

Now we would like to ask you some questions about the achievement of this student's class(es) and your teaching practices.

31

Compared with other class(es) in the same grade in your school, do you feel that the class(es) you teach this student generally has(have).....

- ☐ lower overall academic ability than other classes
- ☐ similar overall academic ability to other classes
- ☐ higher overall academic ability than other classes
- ☐ a greater diversity of academic abilities than other classes
- ☐ there are no other classes at the same grade

32

How often do you use each of the following strategies to teach this(these) subject(s) to the class(es) you teach this student?

	Never	Rarely	Sometimes	Usually	Always
a) Teach to the class(es) as a whole	☐	☐	☐	☐	☐
b) Organize the class(es) into groups having similar abilities in the subject	☐	☐	☐	☐	☐
c) Organize the class(es) into groups having a mixture of abilities in the subject	☐	☐	☐	☐	☐
d) Allow students to form their own groups	☐	☐	☐	☐	☐
e) Use individualized instruction plans to teach the subject(s)	☐	☐	☐	☐	☐
f) Other (specify)	☐	☐	☐	☐	☐

33

How often do you assign homework to the class(es) you teach this student?
(Please include classroom work made intentionally long to be completed out of the classroom)

- ☐ Five days/week
- ☐ Three or four days/week
- ☐ One or two days/week
- ☐ Less than one day/week
- ☐ Never → **Go to QUESTION 36**

34

On the days homework is assigned to the class(es) you teach this student, approximately how much work do you assign?

- ☐ Less than 16 minutes/day
- ☐ 16 to 30 minutes/day
- ☐ 31 to 45 minutes/day
- ☐ More than 45 minutes/day

35

For the class(es) that you teach this student, how often do you monitor homework that you have assigned by:

	Never	Rarely	Sometimes	Usually	Always
a) Keeping a record of who turned in assignments	☐	☐	☐	☐	☐
b) Returning assignments with corrections or grades	☐	☐	☐	☐	☐
c) Discussing homework in class	☐	☐	☐	☐	☐
d) Having parent(s)/guardian(s) sign a homework book/note/agenda	☐	☐	☐	☐	☐
e) Students' own or their peers evaluations	☐	☐	☐	☐	☐

36

Overall, in your class(es) attended by this student, the students in the class(es)...

	Never	Rarely	Sometimes	Usually	Always
a) move smoothly from one classroom activity to another	☐	☐	☐	☐	☐
b) are easily distracted by the disruptive behavior of a few	☐	☐	☐	☐	☐
c) work well together on group activities	☐	☐	☐	☐	☐
d) misbehave when I am called to the door or must attend to other interruptions	☐	☐	☐	☐	☐

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37

Please rate the extent to which each of the following meets the needs of the class(es) that you teach this student.

	Does not meet the needs	Partially meets the needs	Adequately meets the needs	Completely meets the needs	Not applicable
a) Instructional resources (e.g., curriculum documents, books)	☐	☐	☐	☐	☐
b) School supplies (e.g., paper, pencils)	☐	☐	☐	☐	☐
c) Space within your classroom	☐	☐	☐	☐	☐
d) Computers for course instruction	☐	☐	☐	☐	☐
e) Computer software for course instruction	☐	☐	☐	☐	☐
f) Audio-visual resources (e.g., VCR's, film projectors)	☐	☐	☐	☐	☐
g) Science equipment	☐	☐	☐	☐	☐
h) Equipment for mathematics instruction	☐	☐	☐	☐	☐
i) Special equipment for physically disabled/challenged students	☐	☐	☐	☐	☐
j) Library or adequate access to teacher-librarian	☐	☐	☐	☐	☐
k) Gym equipment (e.g., mats, balls)	☐	☐	☐	☐	☐
l) Appropriate locker space	☐	☐	☐	☐	☐

C-4

38

Please indicate the approximate number of minutes per week you spend on the following non-instructional activities for the class(es) that you teach this student:

	Minutes per week			
	0	30 and less	31 to 60	More than 60
a) maintaining order and discipline	☐	☐	☐	☐
b) performing routine tasks (e.g., taking attendance, filling out forms)	☐	☐	☐	☐
c) discussing professional issues with colleagues	☐	☐	☐	☐
d) discussing issues with student's parent(s)/guardian(s)	☐	☐	☐	☐

The next few questions gather information about all the classes you teach, including those to which this student does not belong.

39

Please indicate the approximate number of hours per week you spend on the following non-instructional activities for all classes which you teach (including those to which this student does not belong.

	Hours per week				
	0	Less than 2	2 to less than 3	3 to less than 4	4 or more
a) maintaining order and discipline	☐	☐	☐	☐	☐
b) performing routine tasks (e.g., taking attendance, filing out forms)	☐	☐	☐	☐	☐
c) discussing professional issues with colleagues	☐	☐	☐	☐	☐
d) supervising student at noon/recess	☐	☐	☐	☐	☐
e) assisting/directing extra-curricular activities	☐	☐	☐	☐	☐
f) discussing issues with student's parent(s)/guardian(s)	☐	☐	☐	☐	☐

40

The following statements describe various attributes about yourself and the students in all classes you teach. Please indicate the extent to which you agree or disagree with each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
a) Many of the students I teach are not capable of mastering the curriculum at their grade.	☐	☐	☐	☐	☐
b) The emphasis in my classroom is on the development of academic skills.	☐	☐	☐	☐	☐
c) I have a strong effect on the academic achievement of the students I teach.	☐	☐	☐	☐	☐
d) I feel competent in dealing with students' behavioral problems.	☐	☐	☐	☐	☐
e) I feel competent in dealing with students' learning problems.	☐	☐	☐	☐	☐
f) I feel competent in dealing with students' learning gifts/strengths.	☐	☐	☐	☐	☐
g) I feel students' success at school is determined mainly by their home environment.	☐	☐	☐	☐	☐
h) I have high expectations for the academic success of my students.	☐	☐	☐	☐	☐
i) I push students to achieve their full academic potential.	☐	☐	☐	☐	☐

SECTION 5 Perceptions of Your School

41

Below are a number of statements which describe the climate of your school. Please indicate the extent to which you agree or disagree with each statement.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
a) The administrative, support and teaching staff work together as a team.	☐	☐	☐	☐	☐
b) All staff are involved in decision-making.	☐	☐	☐	☐	☐
c) School staff know what is expected of them in terms of their roles and responsibilities.	☐	☐	☐	☐	☐
d) Staff clearly understand school policies and procedures.	☐	☐	☐	☐	☐
e) teachers have considerable influence on school policies.	☐	☐	☐	☐	☐
f) Teachers have a strong influence on how resources (e.g., money, staff, instructional materials) are allocated.	☐	☐	☐	☐	☐
g) Students clearly understand school rules.	☐	☐	☐	☐	☐
h) The principal and, if applicable, vice principal(s) provide support to teachers.	☐	☐	☐	☐	☐
i) Teachers receive positive feedback from the principal/vice-principal(s)	☐	☐	☐	☐	☐
j) The principal/vice-principal(s) get(s) around the school to talk to the staff.	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
k) The principal/vice-principal(s) spend(s) time getting to know the students.	☐	☐	☐	☐	☐
l) The school provides a positive working environment for teachers.	☐	☐	☐	☐	☐
m) The school provides a positive working environment for students.	☐	☐	☐	☐	☐

42

Please indicate the extent to which you agree with each of these statements regarding your school's disciplinary policies.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
a) Teachers in this school have reached a consensus about ways to discipline students who break rules.	☐	☐	☐	☐	☐
b) All students who break rules in this school face the same consequences.	☐	☐	☐	☐	☐
c) Teachers in this school rarely overlook physical aggression among students.	☐	☐	☐	☐	☐
d) Teachers in this school rarely overlook verbal aggression among students	☐	☐	☐	☐	☐
e) Teachers feel there is insufficient support within the school for managing disciplinary problems.	☐	☐	☐	☐	☐

SECTION 6 Personal Information

Finally, we would like to ask a few questions about yourself and your experiences.

43

Are you.....

☐ Female?
☐ Male?

44

To which age group do you belong?

☐ 20 to 29 years
☐ 30 to 39 years
☐ 40 to 49 years
☐ 50 to 59 years
☐ 60 years or older

45

How much experience do you have as ......
Specify the number of years and months of experience; e.g., 1 year and 5 months

	Years	**Months**	**None**
a) a teacher?	☐	☐	☐
b) a teacher at this grade?	☐	☐	☐
c) a teacher at this school?	☐	☐	☐
d) a teacher in your current subject(s)	☐	☐	☐

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46

Please specify the levels of education you have attained.
(Mark all that apply.)

- ☐ Some coursework towards a Bachelor's degree
- ☐ A teaching certificate, diploma or license
- ☐ A Bachelor's of Education Degree
- ☐ Some post-baccalaureate coursework
- ☐ A post-baccalaureate diploma or certificate
- ☐ Some course work towards a Master's Degree
- ☐ A Master's Degree
- ☐ Some course work towards a Doctorate
- ☐ A Doctorate
- ☐ Trade/vocational certification (including journeyperson)
- ☐ Other, *(Please specify)*

47

Please indicate the main field of study of your highest level of education.

☐ Language Arts (e.g., oral communication, grammar, composition, English as a first language)
☐ Mathematics
☐ Second Language Education
☐ Sciences (e.g., physics, chemistry, biology)
☐ Trade/Vocational
☐ Family Studies
☐ Social Studies (e.g., history, geography)
☐ Environmental Studies
☐ Music
☐ Art
☐ Physical Education
☐ In formatics/Computer Science
☐ Education
☐ Special Education
☐ General (no specialisation/concentration, e.g., B.A. General)
☐ Other *(Please Specify)*

48

Have you obtained any of the following advanced qualifications in special education?
(Mark all that apply)

☐ One class, or part of, a special education program
☐ A special education certificate
☐ A graduate degree in special education
☐ Other
☐ None of the above

49

Have you obtained any of the following advanced qualifications in teaching English as a second language (TESL)?
(Mark all that apply)

☐ One class in, or part of, a second language program
☐ A cerficate in second language education
☐ A graduate degree in second language education
☐ Other
☐ None of the above

Do you have any comments about this survey? If so, please use the space below:_

____

____

____

____

Once completed this questionnaire is confidential. It should not be shown to any other person and should be directly returned to the COPE office.

Your contribution to this effort is greatly appreciated!

Appendix D Physician Interview Guide

Contents:

C.O.P.E. Physician Interview Guide

Physician Interview Guide
March 1999

1. Incentive to be involved:
- Why did you become involved in C.O.P.E.?
- What would motivate a physician to continue to be involved in C.O.P.E.?
- What does it take to initiate and implement a program such as C.O.P.E.?

2. Selection Criteria:
- If we were to replicate this program in another jurisdiction, how would you describe the characteristics/qualities of a physician that would be most suited to being part of a C.O.P.E. team?

3. Professional Development:
- In your experience as part of the C.O.P.E. medical team, what has been your largest area of learning?
- How has your involvement in C.O.P.E. influenced your practice?
- Does your practice/procedures employed at school site visitations differ from your practice/procedures employed in your office?

Working with Teachers:
- How has your exposure to the realities of every-day life in schools affected your assessment and treatment of these children?
- What have you learned from working with teachers?
- What impact have you had on the professional development of teachers?

4. Assessment of C.O.P.E. to Date:
- What are the advantages and disadvantages of the C.O.P.E. program?
    - The top 3 successes
    - The top 3 problems
- How would you improve the program?
- How do school site visitations affect the stress, anxiety and cooperation of parents and children?
- Would C.O.P.E. be a good environment for training of physicians/family liaisons?

5. Team Approach
- How has the opportunity for cross-role dialogue between teachers and physicians influenced your assessment and diagnosis of children?
- In your experience has C.O.P.E. enhanced the quality and access of service for these families?
- How does the C.O.P.E. process affect communication between physicians and teachers, and physicians and parents?
- How would you describe your role in the C.O.P.E. process?
- What do you perceive to be the role of the classroom teacher in the assessment and treatment of children?
- How does the opportunity to meet with teachers affect the referral and assessment process?

6. Cost-Effectiveness
- Are school site visitations an effective use of your time and expertise?
- Are there problems or difficulties encountered in billing for your professional services through C.O.P.E.?
- Is C.O.P.E. cost-effective in terms of early intervention and treatment of children?
- What do you anticipate to be the longer term impact of C.O.P.E. on access to health care and to effective treatment of children?

7. Communication
- Confidentiality; Effective communication between physicians, parents and school
- How does issue of confidentiality regarding what is appropriate to keep in files accessible by the school affect follow-up and treatment of students?

Appendix E C.O.P.E. and CBE Forms

Contents:

C.O.P.E. Behavioural Checklist
C.O.P.E. Referral Forms (study, control)
CBE Consent Form

C.O.P.E.

Community Outreach in Pediatrics/Psychiatry and Education Program

A Typical COPE Profile

Based on referrals from the last year and in consultation with physicians and educators in the elementary schools, the following points profile a potential COPE candidate.

Lack of resources or ability to access resources in these areas:

- Positive parental input
- Disruptive in the classroom
- Underachieving academically
- Physically aggressive or violent
- Socially inappropriate with peers
- Emotionally restricted or sad, has low self-esteem
- Often out of seat, fidgety or squirmy
- Inattentive, distracted/distractible
- Uncoordinated in fine or gross motor skills
- Impaired in hearing or vision
- Fearful, avoidant or clingy
- Odd, bizarre or peculiar in behavior
- Inappropriate sexual in behavior or speech
- Stealing, bullying or non-compliant
- Suicidal or self-harming
- Apparently neglected, abused or appears to be under stress
- Delayed in understanding or using language
- Appears to have health concerns: nutrition, allergies, circles under eyes, etc.

COPE/school working relationship with students will be an essential component to the success of this initiative

STUDY - GROUP

Physician Referral Form

C.O.P.E.

Community Outreach in Pediatrics / Psychiatry And Education Program

Please complete the following information when requesting assessment and consultation services for children and families with learning, behavioural and emotional challenges who have consented to participate in the C.O.P.E. research project.

Patient Demographics – Please stamp information

- What questions would you like answered as part of this referral?

- What type of service is the family looking for at this time and what have they accomplished?

- Are all family members willing to be involved in this assessment? YES _____ NO ______

AREAS OF CONCERN: Please indicate any and all areas of concern

Physical Health / Mental		Destructive to Property	
Family Issues		Theft	
Peer Relationships		Lying	
Separation / Custody		Losses / Depression / Withdrawal	
Speech – Language		Anxiety / Traumatic Events	
Fine / Gross Motor		Hallucinations / Traumatic Events	
Hearing / Vision		Eating Disorder / Body Image Concerns	
Odd / Unusual Behaviour		Substance Abuse	
Academic Performance		Sexual Abuse / Sexually Inappropriate	
Attention / Over-Activity		Physical Abuse	
Social Behaviour Problems		Neglect	
Aggression to People / Animals		Emotional Abuse	
Negative / Hostile / Defiant Behaviours		Domestic Abuse	

SEVERITY / URGENCY:

Situation not urgent ___

Situation requires attention within one month ___

Child is a danger to self and/or others / unpredictable ___

MEDICATIONS / ALLERGIES:

OTHER ASSESSMENTS COMPLETED:
Please indicate reports if available

___ Speech Therapy
___ Occupational Therapy
___ Community Health Nurse
___ Pediatrics
___ Social Services (Income support)
___ Other (specify)
___ Physiotherapy
___ Education
___ Home Care
___ Psychiatry
___ Child Welfare

RELEVANT MEDICAL PROBLEMS – LIST:

OTHER AGENCIES CURRENTLY INVOLVED WITH FAMILY – DOES FAMILY FIND INVOLVEMENT HELPFUL?

OTHER RELEVANT INFORMATION YOU WOULD LIKE TO ADD:

Name of child's regular physician ______________________________

Address ______________________________ Postal Code ____________

Practitioner ULI# ______________ Phone # ______________ FAX # ______________

Physician Signature ______________________________ Date ______________

The personal information on this form is being collected in order to do a medical assessment regarding school learning difficulties, under authority of Section 32 c of the Freedom of Information and Protection of Privacy Act. If you have questions about the process to which this child is being referred please contact: Vandora Moxam, Coordinator COPE Program, Phone 777- 7240 (ext 2251)

THANK YOU. PLEASE FAX THIS FORM TO VANDORA MOXAM AT 777-8103

Control groups

Physician Information Form

C.O.P.E.

Community Outreach in Pediatrics / Psychiatry And Education Program

Please complete the following information for children and families with learning, behavioral and emotional challenges who have consented to participate in the C.O.P.E. Research Project.

Patient Demographics – Please stamp information

- What questions would you like answered as part of this research projectl?
- What type of service is the family looking for at this time and what have they accomplished?
- Have all family members been willing to be involved in assessment of this child's needs? YES ____ NO ____

AREAS OF CONCERN: Please indicate any and all areas of concern

Physical Health / Mental		Destructive to Property	
Family Issues		Theft	
Peer Relationships		Lying	
Separation / Custody		Losses / Depression / Withdrawal	
Speech – Language		Anxiety / Traumatic Events	
Fine / Gross Motor		Hallucinations / Traumatic Events	
Hearing / Vision		Eating Disorder / Body Image Concerns	
Odd / Unusual Behaviour		Substance Abuse	
Academic Performance		Sexual Abuse / Sexually Inappropriate	
Attention / Over-Activity		Physical Abuse	
Social Behaviour Problems		Neglect	
Aggression to People / Animals		Emotional Abuse	
Negative / Hostile / Defiant Behaviours		Domestic Abuse	

SEVERITY / URGENCY:

Situation not urgent ___

Situation requires attention within one month ___

Child is a danger to self and/or others / unpredictable ___

MEDICATIONS / ALLERGIES:

OTHER ASSESSMENTS COMPLETED:
Please indicate reports if available

___ Speech Therapy
___ Occupational Therapy
___ Community Health Nurse
___ Pediatrics
___ Social Services (Income support)
___ Other (specify)
___ Physiotherapy
___ Education
___ Home Care
___ Psychiatry
___ Child Welfare

RELEVANT MEDICAL PROBLEMS – LIST:

OTHER AGENCIES CURRENTLY INVOLVED WITH FAMILY – DOES FAMILY FIND INVOLVEMENT HELPFUL?

OTHER RELEVANT INFORMATION YOU WOULD LIKE TO ADD:

Name of child's regular physician ____________________

Address ____________________ Postal Code ____________

Practitioner ULI# ____________ Phone # ____________ FAX # ____________

Physician Signature ____________________ Date ____________

The personal information on this form is being collected in order to study a medical assessment regarding school learning difficulties, under authority of Section 32 c of the Freedom of Information and Protection of Privacy Act. If you have questions about the process to which this child is being referred please contact: Vandora Moxam , Coordinator COPE Program, Phone 777- 7240 (ext 2251)

THANK YOU. PLEASE FAX THIS FORM TO VANDORA MOXAM AT 777-8103

SE-030 (1999/05)

Calgary Board of Education

Parental Authorization

Direction: *Authorization is a signed statement of informed consent to provide special assistance for the benefit of the student. Signature must be provided by the parent/guardian if the student has not reached the age of majority. If the student is eighteen years of age or older, the student must provide consent instead of parent/guardian.*

Student Identification Information

Student's Name *(Last)* _______ *(First)* _______ *(Initial)* _______

Date of Birth ☐ Yr ☐ Mo ☐ Da

School _______ Teacher _______ Grade/Class _______

Consent (Indicate type ☐ of authorization.)

☐ I hereby consent to the provision of psychological assessment by and consultation with authorized staff employed by the Calgary Board of Education in regards to the exceptional needs of the aforenamed student.

I also acknowledge that I have been informed of the nature and intent of this assessment and I understand that school staff will subsequently review the results of this assessment with me and explain any forthcoming recommendations. It is understood that the psychologist will make the initial interpretation.

☒ I hereby consent to the release to the Calgary Board of Education, and to any duly authorized agent hereof, all the records, reports of examinations, and information of medical, psychiatric/psychological, and/or educational assessments or program rendered to the aforenamed student.

Community Outreach in Pediatrics/Psychiatry and Education (C.O.P.E.)

☒ I hereby authorize the Calgary Board of Education, and any duly authorized agent thereof, to release to:

Community Outreach in Pediatrics/Psychiatry and Education (C.O.P.E.)

Name of school, district, agency, person, etc.

all school records, report assessments, and information of medical, psychiatric, psychological, and/or educational assessments or program rendered to the aforenamed student.

Authorization Signatures

This consent and authorization will be in effect for the current school year.

Name of Consenting Person	Name and Role of School Official
Signature of Consenting Person	Signature of School Official
Date	Date

Please Return To:

Role of School Official _______ Telephone Number _______

☐ Yr ☐ Mo ☐ Da

Address _______

Appendix F Recruitment Letters

Contents:

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CLC Specialist F-2
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2. Prompt letters
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Dec. 8, 1998

Principal
Calgary Board of Education Schools involved in COPE Research Program
Calgary, Alberta

Dear Principal:

As you know, the Community Outreach in Pediatrics/Psychiatry in Education (COPE) program is being administered as a pilot project for 1998-99. During this period of the project's development, a program of research into the effectiveness of COPE is also being administered. The purpose of this letter is to ask for your involvement in the research program.

There are two enclosures in this package. The first is a COPE consent form for Educators. The consent form describes the character of the research and requests your signature, as well as that of a witness, signifying that you understand the research and agree to participate. We would ask that you read and sign this form, and have an adult witness your signature.

The second enclosure is a brief survey questionnaire. The purpose of the questionnaire is to obtain information on how students with emotional, behavioural and learning problems are currently being identified in your school. We also ask about the kinds of data used to inform these decisions, the people involved in the identification process, and the follow-up after the student has been identified as having emotional, behavioural and/or learning problems.

This survey is intended to collect baseline data related to these issues. For schools involved as part of the control groups, we are gathering data on procedures used by the schools at the present time. For schools involved in the COPE program for 1998-99, this survey is to provide baseline data regarding the procedures used to identify students prior to the implementation of COPE. We will be asking you to complete a second survey later in the school year to assess the impact of the COPE program.

We would be grateful if you would sign the consent form, complete the questionnaire, and return both to us in the self-addressed envelope by January 15, 1999. We have asked that you include your name and your school's name on the questionnaire so that we can identify schools in and out of the COPE program, and so that we can track responses over time. However, we would remind you also that your answers will be kept and reported confidentially.

It is extremely important that we receive responses from as many principals as possible. We have purposefully kept the questionnaire brief so as not to impose a burden on your time. We sincerely appreciate your assistance in completing this survey, and would be pleased to answer any questions you may have. Your input will assist in the assessment of the effectiveness of this new program.

Sincerely,

Keith Archer, Ph.D.
COPE Research Director

Lynn Bosetti, Ph.D.
COPE Research Associate

Dec. 8, 1998

Collaborative Learning Communities Specialists
Calgary Board of Education
Calgary, Alberta

Dear CLC Specialist:

As you know, the Community Outreach in Pediatrics/Psychiatry in Education (COPE) program is being administered as a pilot project for 1998-99. During this period of the project's development, a program of research into the effectiveness of COPE is also being administered. The purpose of this letter is to ask for your involvement in the research program.

There are two enclosures in this package. The first is a COPE consent form for Educators. The consent form describes the character of the research and requests your signature, as well as that of a witness, signifying that you understand the research and agree to participate. We would ask that you read and sign this form, and have an adult witness your signature.

The second enclosure is a brief survey questionnaire. The purpose of the questionnaire is to obtain information on how students with emotional, behavioral and learning problems are currently being identified at schools in your CLC. We also ask about the kinds of data used to inform these decisions, the people involved in the identification process, and the follow-up after the student has been identified as having emotional, behavioral and/or learning problems. Where there is variation among the schools in the procedures or personnel used, it would be appreciated if you could elaborate on the differences.

This survey is intended to collect baseline data related to these issues. For CLCs in the control groups, we are gathering data on procedures used at the present time. For CLCs in the COPE program for 1998-99, this survey is to provide baseline data on the procedures used to identify students prior to the implementation of COPE. We will be asking you to complete a second survey later in the school year to assess the impact of the COPE program.

We would be grateful if you would sign the consent form, complete the questionnaire, and return both through inter school mail to us in the self-addressed envelope by January 15, 1999. We have asked that you include your name and your CLC on the questionnaire so that we can identify schools in and out of the COPE program, and so that we can track responses over time. However, we would remind you also that your answers will be kept and reported confidentially.

It is extremely important that we receive responses from as many CLC specialists as possible. We have purposefully kept the questionnaire brief so as not to impose a burden on your time. We sincerely appreciate your assistance in completing this survey, and would be pleased to answer any questions you may have. Your input will assist in the assessment of the effectiveness of this new program.

Sincerely,

Keith Archer, Ph.D.	Lynn Bosetti, Ph.D.
COPE Research Director	COPE Research Associate

Initial

January - June 1999

Teacher
Calgary Board of Education Schools involved in COPE Research Program

Dear Teacher,

As you know, the Community Outreach in Pediatrics/Psychiatry and Education (COPE) Program is being administered as a pilot project for 1998-2000. During this period of the project's development, a program of research into the effectiveness of COPE is also being administered. The purpose of this letter is to ask for your involvement in the research program.

There are two enclosures in this package. The first is a **COPE Consent Form For Educators**. The consent form describes the character of the research and requests your signature, as well as that of a witness, signifying that you understand the research and agree to participate. We would ask that you read and sign this form, and have an adult witness your signature.

The second enclosure is a survey questionnaire. The purpose of the questionnaire is to obtain information on various school factors which may influence the development and education of students with emotional, behavioural and learning problems. We also ask about various classroom/school practices and about yourself as a teacher.

This survey is intended to collect baseline data related to these issues. For schools involved as part of the control groups, we are gathering data on procedures used by the schools at the present time. For schools involved in the COPE Program for 1998-2000, this survey is to provide baseline data on students and classroom practices. We will be asking you to complete a second survey at the end of the project in the Spring of 2000.

We would be grateful if you would sign the consent form, complete the questionnaire, and return both to us in the self-addressed envelope. We have asked that you include your name and the student's name on the questionnaire so that we can track responses over time. However, we would remind you that your answers will be kept and reported confidentially.

It is extremely important that we receive responses from as many classroom teachers as possible. We have purposefully kept the questionnaire as brief as possible so as not to impose a burden on your time. We sincerely appreciate your assistance in completing this survey, and would be pleased to answer any questions you may have. Your input will assist in the assessment of the effectiveness of this new program.

Sincerely,

Keith Archer, Ph.D. COPE Research Director	Lynn Bosetti, Ph.D. COPE Research Associate

Initial
October, 1999
new school year

C.O.P.E.
Community Outreach in Pediatrics/Psychiatry and Education
Parkdale Centre, 728 - 32 St. N.W.
Calgary, Alberta, Canada
T2N 2V9

October 28, 1999

Teacher
Calgary Board of Education Schools involved in COPE Research Program

Dear Teacher:

As you know, the Community Outreach in Pediatrics/Psychiatry in Education (COPE) program is being administered as a pilot project for 1998-2000. During this period of the project's development, a program of research into the effectiveness of COPE is also being administered. The purpose of this letter is to ask for your involvement in the research program.

There are two enclosures in this package. The first is a COPE consent form for Educators. The consent form describes the character of the research and requests your signature, as well as that of a witness, signifying that you understand the research and agree to participate. We would ask that you read and sign this form, and have an adult witness your signature.

The second enclosure is a survey questionnaire. The purpose of the questionnaire is to obtain information on various school factors which many influence the development and education of students with emotional, behavioral and learning problems. We also ask about various classroom/school practices and about yourself as a teacher.

This survey is intended to collect baseline data related to these issues. For schools involved as part of the control groups, we are gathering data on procedures used by the schools at the present time. For schools involved in the COPE program for 1998-2000, this survey is to provide baseline data on students and classroom practices. We will be asking you to complete a second survey at the end of the project in the spring of 2000.

We would be grateful if you would sign the consent form, complete the questionnaire, and return both to us in the self-addressed envelope. We have asked that you include your name and the student's name on the questionnaire so that we can track responses over time. However, we would remind you that your answers will be kept and reported confidentially.

It is extremely important that we receive responses from as many classroom teachers as possible. We have purposefully kept the questionnaire as brief as possible so as not to impose a burden on your time. We sincerely appreciate your assistance in completing this survey, and would be pleased to answer any questions you may have. Your input will assist in the assessment of the effectiveness of this new program.

Sincerely,

Keith Archer, Ph.D.
COPE Research Director

Lynn Bosetti, Ph.D.
COPE Research Associate

Initial
for participants
joining between
Oct 28 and Jan, 00

C.O.P.E.
Community Outreach in Pediatrics/Psychiatry and Education
Parkdale Centre, 728 - 32 St. N.W.
Calgary, Alberta, Canada
T2N 2V9

January 28, 2000

Teacher
Calgary Board of Education Schools involved in COPE Research Program

Dear Teacher:

As you know, the Community Outreach in Pediatrics/Psychiatry in Education (COPE) program is being administered as a pilot project for 1998-2000. During this period of the project's development, a program of research into the effectiveness of COPE is also being administered. The purpose of this letter is to ask for your involvement in the research program.

There are two enclosures in this package. The first is a COPE consent form for Educators. The consent form describes the character of the research and requests your signature, as well as that of a witness, signifying that you understand the research and agree to participate. We would ask that you read and sign this form, and have an adult witness your signature.

The second enclosure is a survey questionnaire. The purpose of the questionnaire is to obtain information on various school factors which many influence the development and education of students with emotional, behavioral and learning problems. We also ask about various classroom/school practices and about yourself as a teacher.

This survey is intended to collect baseline data related to these issues. For schools involved as part of the control groups, we are gathering data on procedures used by the schools at the present time. For schools involved in the COPE program for 1998-2000, this survey is to provide baseline data on students and classroom practices. We will be asking you to complete a second survey at the end of the project in the spring of 2000.

We would be grateful if you would sign the consent form, complete the questionnaire, and return both to us in the self-addressed envelope. We have asked that you include your name and the student's name on the questionnaire so that we can track responses over time. However, we would remind you that your answers will be kept and reported confidentially.

It is extremely important that we receive responses from as many classroom teachers as possible. We have purposefully kept the questionnaire as brief as possible so as not to impose a burden on your time. We sincerely appreciate your assistance in completing this survey, and would be pleased to answer any questions you may have. Your input will assist in the assessment of the effectiveness of this new program.

Sincerely,

Keith Archer, Ph.D.
COPE Research Director

Lynn Bosetti, Ph.D.
COPE Research Associate

Prompt

May 20, 1999

Principal
Calgary Board of Education Schools involved in COPE Research Program
Calgary, Alberta

Dear Principal:

As you know, the Community Outreach in Pediatrics/Psychiatry in Education (COPE) program is currently being implemented as a pilot project within the Calgary Board of Education. During the initial period of the program's development (1998-1999), a program of research into the effectiveness of COPE is also being conducted.

We would like to thank you very much for your time, cooperation, and effort over the last several months in assisting with the implementation of the program.

In early December, we requested your involvement in the research aspect of the project through the completion of a brief survey questionnaire designed to capture how students with emotional, behavioral and learning problems are currently identified and assisted in your school. We have not yet received your completed survey and so we are writing again to request your participation in this aspect of the project.

In order to assess whether COPE improves the situation for schools, parents, and students or not, it is extremely important that we receive responses from as many principals as possible. We would be grateful if you would complete the enclosed **COPE consent form for Educators** and **School Principals Questionnaire**, and return both to us in the self-addressed envelope by **June 15, 1999.**

The consent form describes the character of the research and requests your signature, as well as that of a witness, signifying that you understand the research and agree to participate.

The purpose of the questionnaire is to collect data about the kinds of information used to make decisions in the school context, how various people are involved in the identification process, what services are available to educators and families to assist students, and how access to those services is followed-up after the student has been identified as having problems.

We have asked that you include your name and your school's name on the questionnaire so that we know whether the information you provide applies to the control-group or study-group condition, and so that we can track responses over time. However, we would remind also you that your individual answers will be kept and reported confidentially.

This survey is intended to collect baseline information related to these issues and so we ask that your answers reflect the procedures used by the schools without or prior to the implementation of COPE. A second survey will be sent later in the project to specifically assess the impact of the COPE program.

We would be pleased to answer any questions you may have and can be contacted through the COPE office (777-7240, ext. 2239). Your input will assist in the assessment of the effectiveness of this new program.

Sincerely,

Keith Archer, Ph.D. COPE Research Director	Lynn Bosetti, Ph.D. COPE Research Associate

F-6

Prompt

January 28, 2000

Teacher
Calgary Board of Education Schools involved in COPE Research Program
Calgary, Alberta

Dear Teacher:

As you know, the Community Outreach in Pediatrics/Psychiatry in Education (COPE) program is currently being implemented as a pilot project within the Calgary Board of Education. During the initial period of the program's development (1998-1999), a program of research into the effectiveness of COPE is also being conducted.

We would like to thank you very much for your time, cooperation, and effort over the last several months in assisting with the implementation of the program.

In early November, we requested your involvement in the research aspect of the project through the completion of a survey questionnaire designed to obtain information on various school factors which may influence the development and education of students with emotional, behavioral and learning problems. We have not yet received your completed survey and so we are writing again to request your participation in this aspect of the project.

In order to assess whether or not COPE improves the situation for schools, parents, and students it is extremely important that we receive responses from as many teachers as possible. We would be grateful if you would complete the enclosed **COPE consent form for Educators** and **Teacher Questionnaire**, and return both to us by **February 15, 2000**. **Part A** is to be completed individually for each student in your class who is involved with COPE. **Part B** need only be completed once, regardless of the number of students in your class who are involved with COPE.

The consent form describes the character of the research and requests your signature, as well as that of a witness, signifying that you understand the research and agree to participate.

The purpose of the questionnaire is to collect information about the student in your class who is involved with COPE as well as information about various classroom/school practices and yourself as a teacher.

We have asked that you include your name and the student's name on the questionnaire so that we can track responses over time. However, we would remind also you that your individual answers will be kept and reported confidentially.

This survey is intended to collect baseline information related to these issues and so we ask that your answers reflect the situation without or prior to the implementation of COPE. A second survey will be sent later in the project to specifically assess the impact of the COPE program.

We would be pleased to answer any questions you may have and can be contacted through the COPE office (777-7240, ext. 2239). Your input will assist in the assessment of the effectiveness of this new program.

Sincerely,

Keith Archer, Ph.D.
COPE Research Director

Lynn Bosetti, Ph.D.
COPE Research Associate

F-7

C.O.P.E.
Community Outreach in Pediatrics / Psychiatry and Education Program
c/o Calgary Board of Education,
Parkdale Centre 728 - 32 Street N.W.
Calgary, AB, Canada
T2N 2V9

COPE Consent Form (For Educators)

Research Project Title: COPE, Community Outreach in Pediatrics and Psychiatry in Education

Investigators:	Margaret E. Clarke, MD FRCPC COPE, Program Director	Keith Archer, Ph.D. COPE, Research Director

Sponsor: Alberta Health

Student Identification Information

This consent form a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

____
Student's Name (Last) (First) (Initial)

Date of birth
___/___/___
Yr Mo Day

____
School Teacher Grade/Class

Purpose of the research: A shared concern among parent, educators and doctors is early identification and intervention for children experiencing difficulties with their learning or behaviour in the classroom setting. To assist in getting accurate information about this issue, this study is examining a group of elementary school students enrolled in the Calgary Board of Education, who have been identified as experiencing difficulties with their learning or behaviour in the classroom.

Description of procedures: The student, whose name appears on the top of this consent form, has been selected to participate in this project. The CLC specialist working with the school has contacted you regarding the need for further assessment of the student. This student will meet with staff in the COPE program for pediatric or child psychiatry consultation and/or with teachers and CLC specialists for consultation in a school in his/her area. This child will also be asked to complete several questionnaires about his or her attitudes and behaviour. In addition, you as an educator will be asked to complete several questionnaire about this child's behaviour and about family and school situations.

Research design: Schools have been randomly assigned to 'study groups' and 'control groups'. This student has been assigned to one of these groups based on the school he/she attends. We will reveal the group to which the student was assigned at the conclusion of the study.

Likelihood of discomforts, inconveniences and/or risks: We expect there to be little or no discomforts or inconveniences associated with participation in this study. Participation largely involves completing several questionnaires about current attitudes and current or past behaviours. Participants in the study will experience negligible risks associated with their participation, and some may experience considerable benefits.

What participation entails: Participation entails meeting with staff in the COPE program for pediatric or child psychiatry consultation and/or with teachers and CLC specialists for consultation is a school in his/her area. For participants recruited into the program between November 1, 1998 and Feb. 28, 1999, participation also involves completing one questionnaire of approximately 30 minutes upon recruitment, and two follow-up questionnaires of approximately 15 minutes each, at 4 month intervals. For participants recruited into the program between March 1, 1999 and June 30 1999, participation involves completing one questionnaire upon recruitment and one follow-up questionnaire at a 4 month interval.

F-8

Probability of benefits: The expectation is that early identification and intervention for children experiencing difficulties with their learning or behaviour in the classroom will result in improved learning and better coping skills.

Access to information and subject anonymity: Information gathered in this study will be made available to the research staff of the COPE project. The data will be stored securely, and no identifying information will be stored as part of the study data file. All respondents will have their identity remain confidential.

Information during the course of the research: Data from the research program will not be released during the course of the research (November 1, 1998 – February 28, 2000). At the conclusion of the project, a summary of the information learned will be made available to all participants in this project.

Financial costs. This study will impose no financial costs on participants or their families.

Compensation for injuries: In the event that you suffer any injury as a result of participating in this research, no financial compensation will be provided to you by Alberta Health, the University of Calgary, the Calgary Regional Health Authority, the Calgary Board of Education, the research and program staff. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

Please indicate that you have read the above and consent to participation in this project by signing this consent form.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in this research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Vandora Moxam, Program Coordinator, at 777-7240, ext. 2251

If you have questions about your rights as a possible participant in this research, please contact the Office of Medical Bio-ethics, Faculty of Medicine, University of Calgary, at 220-7990.

Authorization signatures

Name of consenting Person	Name of Witness	Name of Research Staff Member
Signature of Consenting Person	Signature of Witness	Signature of Research Staff Member
Date	Date	Date

A copy of this consent form has been given to you to keep for your records and reference.

The investigator will, as appropriate, explain to your child the research and his or her involvement, and will seek his or her ongoing cooperation throughout the project.

The personal information contained on this form is collected in accordance with provisions as stipulated within the School Act and under the authority of Section 32C of Alberta's Freedom of Information and Protection of Privacy Act for the COPE Research project. If you have any questions about this consent for, please contact Vandora Moxam, Program Coordinator, COPE, Calgary Board of Education, Parkdale Centre, 728 – 32 St. N.W. T2N 2V9, 777-7240 ext 2251.

Appendix G Parent Consent Forms

Contents:

Parent Consent Forms

Study-group.

C.O.P.E.
Community Outreach in Pediatrics / Psychiatry and Education Program
c/o Calgary Board of Education, Parkdale Centre
728 - 32 Street N.W. Calgary, AB, Canada T2N 2V9

COPE Consent Form (For Parents/Guardians)

Research Project Title: COPE, Community Outreach in Pediatrics and Psychiatry in Education

Investigators:	Margaret E. Clarke, MD FRCPC COPE, Program Director	Keith Archer, PhD COPE, Research Director

Sponsor: Alberta Health

Student Identification Information

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

____
Student's Name (Last) (First) (Initial)

Date of birth

___/___/___
Yr Mo Day

____
School Teacher Grade/Class

Parents, teachers and doctors want to find out about and help change the behaviour of children who have learning problems at school. This is a study of how to make this work better in Calgary schools.

Schools have been assigned to 'study groups' and 'control groups'. The main difference is that the study group includes medical doctors in school-based discussions of students. Your child, whose name appears on the top of this consent form, has been chosen for this project. You have already been contacted about the need for further help for your child. Your child will be discussed within the School Resources Group (SRG) team. The SRG will include a pediatrician or a child psychiatrist if you are in the study group. Your child will be asked to fill in several questionnaires about the way they think and feel. Also, you will be asked to complete several questionnaires about your child and about family and school situations.

There are minimal risks associated with your participation in this study, and perhaps considerable benefits.

Participation involves your child meeting with staff in the COPE program for consultation regarding your child's medical, learning, or social and emotional needs, and/or with teachers and program specialists for similar consultation at a school in your area. If you join the program in Nov 1998 to Feb, 1999 you will be asked to fill out one questionnaire which takes about 60 minutes to complete, and two more questionnaires, 4 months and 8 months later, that take about 30 minutes to complete. If you start the program between March 1999 and June 1999 you will be asked to fill out one questionnaire at the beginning, and one more questionnaire 4 months later.

We expect that by finding out about the needs of children having learning or behavior problems in the classroom, and doing something to help them, will result in improved learning, and better coping skills.

The information gathered in this study will be used by the research team of the COPE project. All of the information will be stored in a secure place, and there will be no identifying information on these files. Your identity, and your child's identity, will remain confidential.

The findings of this study will not be released until the study is completed. At that time a summary of what we've learned will be given to those people who participated in the study.

This study will not require any financial costs to you or your family.

If you or your child suffer any injury as a result of being in this study, no financial compensation will be provided to you by Alberta Health, the University of Calgary, the Calgary Regional Health Authority, the Calgary Board of Education, the research and program staff. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

C.O.P.E.

Community Outreach in Pediatrics / Psychiatry and Education Program

Your involvement in this study is very important and valued. We cannot pay you to participate in this study. However, we can reimburse you, up to $15.00 per interview, for any costs that you have, such as bus fare or babysitting costs, to participate in the study.

To show that you have read the information above, and that you agree to be involved in the project, please check each of the boxes below that apply, and sign the consent form.

☐ I request that my child (named above) be referred to the COPE program for pediatric or child psychiatry consultation.

☐ I acknowledge that I have been informed of the nature and intent of this assessment and I understand that school and/or medical staff involved with this program will review the results of this assessment with me and explain any recommendations.

☐ I understand that I will be fully informed of the findings and recommendations.

☐ I provide consent for my child's doctor to disclose the information requested on page 4 of this form to the medical and research staff involved with this program.

☐ I provide consent for the Calgary Board of Education, and any duly authorized agent thereof, to release to the COPE program all school records, report assessments, and information of medical, psychiatric, psychological and/or educational assessments or program rendered to my child.

☐ I have read the information above. I understand the nature of the research, and I understand that as a participant in this study, my child will complete two or three interviews. I understand my child may withdraw from the study at any time, and this withdrawal will have no impact on his/her participation in this program. I consent to my child's participation in this study under these terms and conditions.

☐ I have read the information above. I understand the nature of the research, and I understand that as a participant in this study, I will complete two or three interviews. I understand that I may withdraw from the study at any time, and this withdrawal will have no impact on my child's participation in this program. I consent to participate in this study under these terms and conditions.

Your signature on this form indicates that you have understood to your satisfaction that information regarding participation in this research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Vandora Moxam, Program Coordinator, at 777-7240, ext. 2251
If you have questions about your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

Authorization signatures

Name of consenting Person	Name of Witness	Name of Research Staff Member
Signature of Consenting Person	Signature of Witness	Signature of Research Staff Member
Date	Date	Date

A copy of this consent form has been given to you to keep for your records and reference.

The investigator will, as appropriate, explain to your child the research and his or her involvement, and will seek his or her ongoing cooperation throughout the project.

The personal information contained on this form is collected in accordance with provisions as stipulated within the School Act and under the authority of Section 32© of Alberta's Freedom of Information and Protection of Privacy Act for the COPE Research project. If you have any questions about this consent for, please contact Vandora Moxam, Program Coordinator, COPE, Calgary Board of Education, Parkdale Centre, 728 – 32 St. N.W. T2N 2V9, 777-7240 ext 2251.

Control groups

C.O.P.E.
Community Outreach in Pediatrics / Psychiatry and Education Program
c/o Calgary Board of Education,
Parkdale Centre 728 – 32 Street N.W.
Calgary, AB, Canada
T2N 2V9

COPE Consent Form (For Parents/Guardians)

Research Project Title: COPE, Community Outreach in Pediatrics and Psychiatry in Education

Investigators:	Margaret E. Clarke, MD FRCPC COPE, Program Director	Keith Archer, PhD COPE, Research Director

Sponsor: Alberta Health

Student Identification Information

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Student's Name (Last) (First) (Initial)

Date of birth ___/___/___ Yr Mo Day

School Teacher Grade/Class

Parents, teachers and doctors want to find out about and help change the behaviour of children who have learning problems at school. This is a study of how to make this work better in Calgary schools.

Schools have been assigned to 'study groups' and 'control groups'. The main difference is that the study group includes medical doctors in school-based discussions of students. Your child, whose name appears on the top of this consent form, has been chosen for this project. You have already been contacted about the need for further help for your child. Your child will be discussed within the School Resources Group (SRG) team. The SRG will include a pediatrician or a child psychiatrist if you are in the study group. Your child will be asked to fill in several questionnaires about the way they think and feel. Also, you will be asked to complete several questionnaires about your child and about family and school situations.

There are minimal risks associated with your participation in this study, and perhaps considerable benefits.

Participation involves your child meeting with staff in the COPE program for consultation regarding your child's medical, learning, or social and emotional needs, and/or with teachers and program specialists for similar consultation at a school in your area. If you join the program before March 1999 and September 1999, you will be asked to fill out one questionnaire which takes about 60 minutes to complete, and two more questionnaires, 4 months and 8 months later that take 30 minutes to complete. If you start the program after September 1999, you will be asked to fill out one questionnaire at the beginning and one more questionnaire 4 months later.

We expect that by finding out about the needs of children having learning or behavior problems in the classroom, and doing something to help them, will result in improved learning, and better coping skills.

The information gathered in this study will be used by the research team of the COPE project. All of the information will be stored in a secure place, and there will be no identifying information on these files. Your identity, and your child's identity, will remain confidential.

The findings of this study will not be released until the study is completed. At that time a summary of what we've learned will be given to those people who participated in the study.

This study will not require any financial costs to you or your family.

If you or your child suffer any injury as a result of being in this study, no financial compensation will be provided to you by Alberta Health, the University of Calgary, the Calgary Regional Health Authority, the Calgary Board of Education, the research and program staff. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

C.O.P.E.

Community Outreach in Pediatrics / Psychiatry and Education Program

Your involvement in this study is very important and valued. We cannot pay you to participate in this study. However, we can reimburse you, up to $15.00 per interview, for any costs that you have, such as bus fare or babysitting costs, to participate in the study.

To show that you have read the information above, and that you agree to be involved in the project, please check each of the boxes below that apply, and sign the consent form.

☐ I provide consent for my child's doctor to disclose the information requested on page 4 of this form to the medical and research staff involved with this program.

☐ I provide consent for the Calgary Board of Education, and any duly authorized agent thereof, to release to the COPE program all school records, report assessments, and information of medical, psychiatric, psychological and/or educational assessments or program rendered to my child.

☐ I have read the information above. I understand the nature of the research, and I understand that as a participant in this study, my child will complete two or three interviews. I understand my child may withdraw from the study at any time, and this withdrawal will have no impact on his/her participation in this program. I consent to my child's participation in this study under these terms and conditions.

☐ I have read the information above. I understand the nature of the research, and I understand that as a participant in this study, I will complete two or three interviews. I understand that I may withdraw from the study at any time, and this withdrawal will have no impact on my child's participation in this program. I consent to participate in this study under these terms and conditions.

Your signature on this form indicates that you have understood to your satisfaction that information regarding participation in this research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Vandora Moxam, Program Coordinator, at 777-7240, ext. 2251
If you have questions about your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

Authorization signatures

Name of consenting Person	Name of Witness	Name of Research Staff Member
Signature of Consenting Person	Signature of Witness	Signature of Research Staff Member
Date	Date	Date

A copy of this consent form has been given to you to keep for your records and reference.

The investigator will, as appropriate, explain to your child the research and his or her involvement, and will seek his or her ongoing cooperation throughout the project.

The personal information contained on this form is collected in accordance with provisions as stipulated within the School Act and under the authority of Section 32© of Alberta's Freedom of Information and Protection of Privacy Act for the COPE Research project. If you have any questions about this consent for, please contact Vandora Moxam, Program Coordinator, COPE, Calgary Board of Education, Parkdale Centre, 728 – 32 St. N.W. T2N 2V9, 777-7240 ext 2251.

Appendix H Illustrative Case Studies

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Illustrative Case Studies

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Case I: Moderate Emotional and Behavioral Difficulties

Cynthia Walker is a 6th grade student in a school situated in a middle to upper income neighborhood. Her parents are professionals with post-secondary education who have actively been seeking medical intervention for their daughter since she was aged 4. They have been concerned about their daughter's weight loss, anxiety and unreasonable fears. The family has been referred by the family physician to an internist and a psychologist. They have resorted to using the Emergency Services at the Alberta Children's Hospital as a last resort to addressing their daughter's fears.

As a result of these interventions the family had come to view Cynthia's behavior as attention seeking behavior and psychological in nature. They felt unsupported by the medical system, ineffective as parents, and at a loss in helping their daughter. The daughter was feeling emotionally distraught, was increasingly reluctant to attend school or to participate in activities outside of the home. The family was under extreme duress. It was at this point that the mother met with the principal seeking help. The principal took the case to C.O.P.E.

Impact of C.O.P.E.: The parents and child had three meetings with the C.O.P.E. pediatrician, and the C.O.P.E. files record 19 telephone contacts with the parent or teacher regarding this case. The principal remained involved and supportive throughout, and attended two of three meetings with the C.O.P.E. team and the family.

The parents reported that the C.O.P.E. consultation was effective because it was child-focused. In the first consultation the physician helped Cynthia and the family to understand the nature of the problem, and they were given literature and references to continue to read about and understand their daughter's condition. They were referred to a child psychologist who had specific expertise in children's phobias and fears, and through counseling Cynthia has acquired skills and strategies to address her fears. The C.O.P.E. physician and the principal had a concluding session with Cynthia and her family to celebrate her progress. During this meeting Cynthia disclosed that she is now considering a career as a psychologist.

Discussion: There are a number of factors that contributed to the success of this case. First and foremost is the reality that Cynthia's parents were actively seeking support and assistance to address the needs of their child. They were well integrated into the health care system, as evidence by their use of a primary care physician and referrals to other specialists. C.O.P.E physicians were effective in accurately diagnosing the problem and referring the child and family to an appropriate and skilled psychologist. They provided immediate feedback to the family and reassurance to the child. The parents were diligent in implementing recommendations made through C.O.P.E.

There was a system of care built up around Cynthia to support her recovery. She had committed and caring parents, and an empathetic school principal who served as the liaison between the family, C.O.P.E., and the school, and who was committed to assisting the child and family access appropriate care. The teacher, while initially unaware of the problem, was supportive and sensitive to ensuring confidentiality of issues related to the case. This was evidenced by her telephone calls regarding participation in the C.O.P.E. research. In summary, there was general agreement among all participants of the diagnosis of the problem and a commitment to implementing the recommendations made through C.O.P.E. Cynthia was not going to slip through the cracks because of the support system surrounding her.

Case II: Complex Case of Learning, Social and Emotional Problems Confounded by a Chaotic Home Environment.

Arlene Drinkwater is an 11-year-old student in 6th grade in a school situated in a lower income neighborhood. Since Grade 2 Arlene has attended five different schools. She was referred to C.O.P.E. by her teacher because she appeared to be withdrawn in school, lacking in social skills, had poor personal care, had no friends and there was the possibility of her being depressed. Results of psycho-educational testing conducted on two separate occasions suggest that she is of low average ability.

Arlene's mother is aware of her daughter's problems and attributes her shyness and withdrawnness to her daughter's "speech impairment" and fear of being teased. She also mentions that Arlene is subject to teasing at home from an older sister, and to the aggressive behavior of her younger brother. The mother speaks as a strong advocate for ensuring that Arlene receives access to appropriate services, testing and support in the school. She is able to name the kinds of tests she would like to be given to her daughter and the kinds of programs her daughter might enter. The C.O.P.E. files record numerous telephone conversations with the mother regarding her demand for treatment for her daughter in spite of the attempts of the family liaison to explain that C.O.P.E. is about identification and not treatment. The family liaison has completed two home visits and reviewed all recommendations made by the physicians with the mother. There are a number of recommendations made to enhance Arlene's self esteem and to improve her social skill through community programs, however, the family has not accessed any of these services. The mother reports dissatisfaction with the C.O.P.E. program because her daughter's academic achievement is not improving, and she does not appear to be accessing "professional" treatment. The mother reports working with her daughter to complete her homework. The main concern of the mother is her daughter's low academic achievement. In her view Arlene is a happy and outgoing child at home.

In this case there are many discrepancies between what the mother reports in her interview and survey, with what the teacher observes and reports in her survey, and with what the physician records in the C.O.P.E medical records. For example, in the interview the mother reports that Arlene lives at home with her, the stepfather and three siblings ranging in ages from 7 to 14. Her mother maintains that she works night shift and her husband works day shifts and that she is very involved in her daughter's schooling. In contrast, the physician's report indicates that Arlene lives with her mother, who is home full-time and baby-sits four children, her three siblings, and with her mother's fiancé who works construction. The teacher reports that the parents demonstrate little interest or involvement in Arlene's schoolwork, they don't attend parent-teacher interviews, that her homework is almost never complete, and that she often comes to school dressed inadequately for the weather. The teacher expresses concern that Arlene is unhappy, depressed, tearful, and inattentive, has low self-confidence and is solitary.

Impact of C.O.P.E: The mother suggests that C.O.P.E. has had no impact on Arlene or the family because it only deals with the identification of problems and recommendations, rather than providing treatment. There is a lack of agreement among the mother and the physician and the school regarding the nature of Arlene's problem. The mother wants only to focus on Arlene's low academic achievement, and the others are concerned about her social and emotional problems. The mother wants solutions and the problem to be addressed by the school, the others want her to understand the problem and to access mental health and community services. There was only one consultation between the family, school and physicians, however there was considerable follow-up by the family liaison and school administration. There are 19 telephone contacts among the school and family recorded in the C.O.P.E files.

Discussion: This case illustrates some of the complexities involved in dealing with children whose presenting pathology is confounded by a chaotic and unsupportive home environment. In this case the mother appears to be crisis driven rather than action oriented in the sense that Arlene has been undergoing various assessments related to academic ability, she has had some speech therapy, and limited mental health therapy. The school has responded by providing Arlene with an Individualized Program Plan and an Auditory Processing Assessment, they are monitoring her anxiety and withdrawn behavior, they are providing her with assistance to help her transition to another new school; however, in all instances require that her mother also be involved. While her mother is vocal and demands to be informed and involved, there is less evidence that she is willing to actually implement recommendations made to her. Upon closer investigation of the home environment there is evidence that Arlene is being subject to physical abuse by her siblings. This is a case where there is clearly the need for more family support and access to mental health services for the family; however, C.O.P.E has focused attention to Arlene's problems and has the school aware of the complexities of the difficulties.

Case III: Mild to Moderate Developmental Problems

Erin Hemple is an active and happy six-year-old repeating Kindergarten in a school situated in a middle-income neighborhood. His father has post-secondary education; his mother has some post-secondary training and is at home full time to care for him and his younger brother.

Erin's mother reports that she has been concerned with her son's development since he was a baby because he was slow to walk and talk, his behavior was inappropriate with other children and his motor-skills appeared to be slow in developing. She was reluctant to put him into Kindergarten but the school advised against delayed entry. She claims that she has taken her son to a pediatrician but with little result, her family physician billed her $20.00 for a referral to C.O.P.E., and in her opinion has been unsupportive of assisting her to get help for her son's problems. Erin's teacher recommended him to the C.O.P.E program with the strong support of his family.

On the first consultation Erin and his family met with the C.O.P.E. team and the school resource teacher to review his case. At this meeting the developmental pediatrician gathered background data from the parents and the school, conducted a preliminary physical examination and made recommendations. These included suggestions for further speech and language testing through the school psychologist, and the recommendation that the parents look into other more suitable, yet private programs for their son such as Renfrew Academy and the Learning Centre. The physician also provided the family and teacher with additional literature to help them to better understand sensory integration. The parents were given a few strategies and exercises to use with their son at home.

The physician then conducted further assessments in his two classroom visitations. During these visits he made classroom observations, conducted a Pediatric Examination of Educational Readiness (PEER) and consulted with the teacher regarding the development of an Individualized Program Plan for Erin, and other strategies she might use in the classroom. The school resource teacher was apprised of the recommendations made in these visits. The physicians met a second time for debriefing with the family and teacher to review the results of his assessments. It was determined that further follow-up with the family and the school would be managed by the family liaison.

Impact of C.O.P.E.: In this case the parents report being dissatisfied with the outcome of C.O.P.E. because they expected to receive professional intervention in the school. While the parents were pleased to have the results of their son's assessment and to gain knowledge of his specific problem areas, they were frustrated that they did not receive specific referrals to other services in the community. They wanted contact names and telephone numbers. Instead, they received recommendations for other services and were given the name of places to contact; however, these services were in the private education/health domain and for a single income family not plausible. They were recommended for further assessment at the Alberta Children's Hospital, but after a one-hour telephone interview, were not accepted as a candidate for further testing through this venue.

The mother claimed that her son's progress could be attributed to working with his teacher, and to her commitment to working with him at home, rather than to C.O.P.E. She applauded the teacher's commitment and assistance in giving her strategies and work for him to do at home, and for putting her son on an individualized program plan. The teacher reports that C.O.P.E has been instrumental in identifying and defining Erin's areas of difficulty and in recommending him for further testing through the school. She claims that it has been "invaluable" having a pediatrician in the school to consult with, to make classroom observations, and recommendations. She also attribute's Erin's progress to working as a team with the mother (who contacts the school twice a week to discuss her son's progress and behavior in class), and to having the knowledge and skills to effectively address his learning and social needs.

Discussion: This case is an example of how C.O.PE. is able to build a system of care for a child at the school level. Through accurate identification of the child's problems the school and health providers were able to create a program at the school level, and to monitor his progress. While the parents would like more professional intervention at the school level and do not feel they should have to access outside resources, it appears that the teacher is satisfied that they are effectively dealing with Erin through the school system. The teacher who is an experienced early childhood teacher, has benefited from one-on-one consultation with a developmental pediatrician who helped her understand how to better deal with such difficulties in a classroom setting. The school is aware of Erin's problems and is monitoring his progress.

General Discussion: The above cases illustrate the different ways in which C.O.P.E. is realized in practice. It is evident that while there is a basic model to the C.O.P.E. process, that in practice the model is influenced by the very idiosyncratic nature of each case. This is influenced by the style and practice of the physician, the capacity and willingness of the parents to implement recommendations made, and the capacity of the school system to support the student. In all three cases C.O.P.E has been instrumental in the identification of a child with specific difficulties and has set in motion the creation of a system of care for the child in the sense that both the school and parents are aware of the problem, they share the recommendations, and in some cases they have accessed other support services in the community. The responsibility for the child is not shifted away as it might be if the child was seen only through a clinic or private practice.